URGE SURFING FOR ACUTE AND POST-ACUTE RECOVERY POPULATIONS

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ABSTRACT

Mindfulness-Based Relapse Prevention urge surfing is an intervention that promotes distress tolerance through acceptance of and non-reactivity to urges and cravings. While the urge surfing intervention is effective with participants in out-patient and early recovery settings, for which it was designed, there is no research literature related to its efficacy for clients receiving higher level of care services during early abstinence and recovery. Clients undergoing residential treatment for substance use concerns are likely to experience difficulty with a cognition based approach such as urge surfing, due to cognitive dysfunction related to post-acute withdrawal in early recovery. A modification of the urge surfing intervention that replaces an abstract cognition dependent visualization with a focus on immediate and concrete somatic distress creates the potential of making it useful for populations in early recovery.

Keywords: Urge surfing, distress tolerance, post-acute withdrawal, substance abuse treatment

Table of Contents

Urge Surfing for Post-Acute Residential Recovery Populations

Martin Luther said, "They are damned who flee damnation, for Christ was of all the saints, the most damned and forsaken" (Eire, 2016; p. 144). Luther had been faced with painful anxiety based on his perception that he was forsaken by God. On the guidance of his monastic superiors, he had sought ways to ameliorate his pain through hard work and other distractions with unsatisfactory results. When, however, Luther read in Psalms 22, the words of Jesus on the cross, "My God, my God, why have you forsaken me", he had an epiphany that his own salvation would be achieved *through* his anxiety, despair, and suffering, not by avoiding it (Eire, 2016). Similarly, the path of those individuals in substance abuse recovery appears to go through aversion and distress, rather than around it.

It is not the aim of this paper to propose urge surfing as a soteriological intervention. Rather, this paper investigates the necessity of adapting urge surfing, a Mindfulness-Based Relapse Prevention intervention designed for aftercare and outpatient populations, to early recovery populations experiencing acute and post-acute withdrawal. There are three factors operating in the recovery and relapse prevention environments that support the need for this type of intervention in early recovery. The first factor is that withdrawal symptoms and automatic mental responses, such as urges and cravings, drive relapse, with avoidance of withdrawal symptoms, urges, and cravings being a primary precipitant to resumption of substance use (Hsu, Collins, & Marlatt, 2013; Tiffany, Friedman, Greenfield, Hasin, & Jackson, 2012; Witkiewitz, Bowen, Douglas, & Hsu, 2013).

The second factor is that continuity of services from residential to outpatient or aftercare is not guaranteed, with attrition rates typically being high and continuity in services being low (Acquavita, Stershic, Sharma, & Stitzer, 2013; Carter et al., 2008; Lindahl, Berglund, &

Tönnesen, 2013; Luoma, Kulesza, Hayes, Kohlenberg, & Larimer, 2014). Under these circumstances, it is likely that the primary window of opportunity for providing tools and interventions for relapse prevention may only exist in the short period that an individual is present in a residential or early recovery program. Given this fact, an intervention which is brief, immediate, experiential, and specifically created to target urges, craving, and distress tolerance can be of considerable benefit (Bowen, Chawla, & Marlatt, 2011).

A third factor, which demonstrates the need for a mindfulness approach specifically in Alaskan residential treatment programs, is the prevalence of American Indian and Alaska Native participants in recovery programs, both nationally and in Alaska (Substance Abuse and Mental Health Services Administration [SAMSHA], 2012; SAMSHA, 2014). It is impossible to make an accurate, broad brush characterization of 561 nations and tribes, each with its own discreet culture, history, socioeconomic situation, and intellectual orientation and worldview. However, in an effort to decolonize the discourse on mental health and substance abuse treatment, traditional American Indian and Alaska Native learning has been portrayed as moving from experiential, temporally immediate, and empirical in nature to abstract, in juxtaposition to Western European learning, which is received, begins with the abstract, and is validated by the empirical (Barnhardt & Kawagley, 2005; Burch, 1994; Deloria Jr., 2012; Gone, 2009). Mindfulness approaches may be characterized as immediate and experiential; therefore, they may be compatible with a system of knowledge based on direct experience, suggesting that it may be a critical component to a culturally competent treatment approach in Alaskan residential programs.

There are two questions that will be addressed in the following literature review. First, is an intervention that develops acceptance and non-reactivity to urges, craving, and distress, also

known as urge surfing, critical to early recovery? Second, given that urge surfing is a cognition based activity, with sustained visualization at its core, can it be adapted for use with people in early recovery who are experiencing both cognitive and somatic disruptions?

The first questioned can be answered through an examination of the literature on addiction, urges and cravings, distress tolerance, and recovery, as well as the literature on acute and post-acute withdrawal symptomology. However, a gap in the literature exists regarding the second questions. Although research and literature is available regarding the validity of employing awareness, acceptance, and non-reactivity, also known as urge surfing, as an intervention for urges, craving, and distress in substance abuse aftercare, there is an absence of research or literature that addresses the use of urge surfing with acute and post-acute populations specifically. This gap presents a problem for two reasons. First, early recovery populations experience high rates of relapse driven by urges, craving, and low distress tolerance, and can directly benefit from an intervention which targets these factors (Daughters, Lejuez, Bornovalova, et al., 2005; Hsu et al., 2013; Schauss, 2012; Witkiewitz, Bowen, et al., 2014). Second, the effects of acute and post-acute withdrawal related cognitive deficits on a cognition based intervention remain unexamined, and consequently therapeutic solutions that address this complication are underdeveloped.

Subsequently, this paper has four aims. The first aim is to explore the role of urges, cravings, and distress in addiction and recovery in order to demonstrate the need for a targeted intervention. The second aim is to present an argument that urge surfing is an ideal, theoretically grounded intervention which can be adapted to serve individuals experiencing acute and post-acute withdrawal related cognitive deficits. The third aim is to demonstrate that acute and post-acute withdrawal present obstacles to the implementation of cognition based interventions,

including urge surfing. The fourth aim is to demonstrate a useful adaptation of urge surfing and its application within a residential treatment setting.

Overview

Urge surfing is a distress tolerance, urge and craving management intervention from the curriculum of the Mindfulness-Based Relapse Prevention (MBRP) recovery approach (Bowen, Chawla, & Marlatt, 2011). The MBRP approach is derived from a combination of the Cognitive Behavioral Relapse Prevention and Mindfulness practices (Bowen et al., 2014; Witkiewitz, Marlatt, & Walker, 2005). Urge surfing specifically targets automatic mental responses, such as cravings and urges, as mediators for substance use and relapse. In addition to an argument that urge surfing is applicable to a post-acute recovery population, preliminary evidence suggests that MBRP and urge surfing is, or can be, a culturally competent intervention for treatment programs serving Alaska Native and American Indian populations. When possible the cultural relevance or congruence of urge surfing to the Alaskan substance abuse treatment milieu is explored in this literature review.

To illustrate the centrality of the need for an intervention which specifically targets urges and cravings, this literature review begins with an exploration of addiction, urges and craving, distress tolerance, definitions of recovery, and descriptions of relevant recovery models, orientations, approaches, and interventions. Further on, this literature review examines acute and post-acute withdrawal symptoms that on one hand obstruct cognitive interventions, but on the other contribute as precipitating cues to a somatically based interpretation of urge surfing. A summary of research supporting this use of yoga based therapeutic approaches, emphasizing the practice of acceptance and non-reactivity through postural, cued physical distress that approximates withdrawal related physiological agitation is provided in the literature review. To

conclude, argument is supported that distress caused by withdrawal symptoms can be reinterpreted as a tool to facilitate progress in early recovery, similar to ways in which physical experiences are used for self-regulation and self-acceptance in physical systems like yoga.

Addiction, Urges and Craving, and Distress Tolerance

A central factor in addiction is the involuntary, physiological experience of automatic mental responses, also known as urges and cravings (Ostafin & Marlatt, 2008; Witkiewitz et al., 2005). Automatic mental responses are subjective experiences cued by distress or perceived need (Witkiewitz, Lustyk, and Bowen, 2013), and can be conceptualized as the impetus that translates thoughts of escape and avoidance into the action of substance use and abuse. Unskillful attempts to suppress or change automatic mental processes can result in their reinforcement, creating a latent potential for delayed resurgence (Bowen et al., 2011). Also, doing nothing to develop skill in coping with automatic mental processes will of course limit the efficacy of the recovery effort. The following section explores the role of distress tolerance and automatic mental responses in addiction and recovery.

Addiction

There is a daunting multiplicity of addiction models and definitions available. In response to this, Simon and West (2015) worked to create an overarching classification of them, placing over 20 discreet addiction models into two broad categories. These categories differ in terms individual or group/population dynamics. Each of these broad categories are further divided into subcategories of similarly themed models containing individual operational definitions of addiction based on biological, neurological, psychological, or sociological factors, and run the gamut from the impact of dopaminergic processes on the reward system to socio-economic and market forces (Simon & West, 2015). Out of this continuum, it becomes apparent that there are a

number of models, which are best conceptualized based on theoretical orientation and treatment approach. In an independent review of the current literature regarding theories of addiction, the primary orientations and approaches that emerge are behavioral, biological/disease, motivation, and wellness.

A standard and broadly accepted conceptualization of the biological/disease model is offered by the American Society of Addiction Medicine (American Society of Addiction Medicine [ASAM], 2011), which states that addiction is "a primary, chronic disease of brain reward, motivation, memory, and related circuitry" (p. 1). This dysfunction of circuitry is characterized by an "inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response" (ASAM, 2011, p. 1). Through this definition, ASAM focuses on the biological aspects, causations, and consequences of the process of addiction, including the automatic mental response of craving.

In comparison, models that focus on motivation identify the role that motivation, or lack thereof, can have on the addiction process. For example, Del Boca and Darkes (2012) conceptualize addiction as a distortion of the motivation system that has become pathological and may be dominated by motivational proxies such as craving. In this process, addiction overtakes the motivational system, redirecting it towards obtaining, utilizing, and maintaining the use of addictive substances. In this construct, automatic mental processes, such as urges or cravings can come to dominate the motivational system, perpetuating habitual use patterns.

Instead of focusing on a singular process, definitions of addiction that are wellness based embrace a holistic approach. Such models are supported for use with American Indian/Alaska Native populations, as well as harm reduction models. For example, Croff, Rieckman, and

Spence (2014), referring primarily to an American Indian and Alaska Native worldview, state that addiction is not symptom specific, but can be related to restoring balance and the health of the whole person. In the holistic approach, the focus is on attaining overall balance and improving quality of life, which in the final analysis revolves around mediating internal and external triggers or events that can influence an individual's urge or craving to use.

Perhaps the most extensively identified orientation is that of behavioral adaptation. The American Psychiatric Association (American Psychiatric Association [APA], 2013) avoids the term addiction due to its negative connotation, preferring instead the term substance use disorder. A substance use disorder may be defined as a state of chronically, relapsing, compulsive substance use (APA, 2013). In addition, Randle, Stroink, and Nelson (2015) describe addiction as a debilitating disorder that is characterized by persistent substance seeking behavior in the face of burgeoning negative outcomes and a desire to cease use. In these definitions, the authors recognize the progression of reinforced behaviors leading to a seemingly inevitable end. Further, George, Koob and Vendroscolo (2014) assert that addiction is a progression through the steps of use, abuse, and dependence that results from the relationship between an individual and their milieu. Through this definition, the authors give credence to the progressive nature of behavioral adaptation and reinforcement which leads to conditioned and automatic mental processes.

Similarly, the Cognitive Behavioral based Relapse Prevention approach to recovery also addresses behavioral adaptation. Relapse Prevention is one of two approaches, along with Mindfulness, that form the basis of MBRP, and subsequently inform urge surfing (Khanna & Greeson, 2013). According to Witkiewitz and colleagues (2005), the Relapse Prevention approach to recovery is based on the idea that substance use disorders are learned behaviors arising from situational, social, affective, and cognitive stimuli or precipitators. Critical elements

of this approach to addiction are deficits in coping skills, automatic mental responses, such as urges and cravings, low self-efficacy, erroneous expectancies about positive outcomes related to substance use, and internal and external high risk substance use situations (Witkiewitz et al., 2005). Urges and cravings are at the heart of the above definitions of addiction, and it is to these automatic mental responses that attention is now turned.

Urges and Craving

As a component of addiction, craving manifests as either a strong desire to maintain or attain a positive, dopaminergic state, or a strong aversion to a negative state, resulting in avoidance (Witkiewitz et al., 2013). Craving is often conflated with urge in popular parlance. Although the terms urge, "a sudden impulse to engage in an act", and craving, "a subjective desire to experience the effects of that act" are distinct in meaning, the same processes (conditioning by past and anticipated gratification) may mediate both states (Larimer, Palmer, & Marlatt, 1999, p. 155). From this definition, it may be understood that a craving does not exist without an urge, as a craving is a desire to experience perceived potential outcomes of satisfying the urge.

With regard to substance use, craving was identified by Volz and colleagues (2014) as being a result of daily environmental stressors (hassles) in combination with low distress tolerance. Witkiewitz and colleagues (2005), echoing Larimer and colleagues (1999), indicate that craving is a cognitive mechanism "with stimulus properties" that may be described "as a representation of the desire to use a substance" (p. 33). Ostafin and Marlatt (2008) characterized craving as an "automatic appetitive response" which influences behavior (p. 406). Self-efficacy in management of craving is correlated with high motivation to find alternative pathways to coping and problem resolution in high risk situations (Witkiewitz et al., 2005). From these

sources, it appears that craving is an automatic and unavoidable experience that drives addictive behavior.

As such a formidable factor, craving is universal to addiction theories and is central to any discussion or research on the subject (Tiffany & Wray, 2012). Craving is described by individuals in recovery as a major obstacle to sustained abstinence. It is specified in clinical research studies as a reliable predictor for relapse, being identified as pervasive across substance use disorder types and substance categories, and having strong predictive and diagnostic applicability (Tiffany et al., 2012: Witkiewitz et al., 2013). Larimer and colleagues (1999) state that even with the support of comprehensive treatment regimens, most people in recovery cannot avoid cravings. These findings suggest that skills must be developed to cope with automatic mental responses such as cravings and urges in order for any treatment approach, including residential modalities, to be effective.

Distress Tolerance

Craving can both be precipitated by distress, and it can trigger distress. Consequently, low distress tolerance is a predictor of relapse. Anestis, Selby, Fink, and Joiner (2007) define distress tolerance as "the degree to which the experience of negative affect is deemed unbearable" (p. 2). Volz and colleagues (2014) offer that individuals with low distress tolerance are quick to experience goal disruption due to "physical or affective discomfort" (p. 872) and that interventions for increasing distress tolerance would facilitate the goal of abstinence. Daughters, Lejuez, Bornovalova, et al. (2005) defined distress tolerance as the capability to encounter negative affect without turning to self-defeating or non-productive coping strategies. Further, they explain, when faced with distress, individuals served by residential substance abuse programs may resume substance use to mitigate treatment related negative affective states,

suggesting a possible cause for relapse and discontinuation of services (Daughters, Lejuez, Bornovalova, et al., 2005).

Distress tolerance in combination with a sense of urgency (i.e. a strong urge, which is an automatic mental response) cued by a negative affective state can result in impulsivity, negative coping strategies, and other complications to recovery (Anestis et al., 2007). In fact, avoidance of negative affect is a primary motive, along with escape from negative physiological withdrawal symptoms, for relapse in alcohol and other drug abusing populations (Hsu et al., 2013). Therefore, development of a capacity to tolerate cognitive and somatic distress may be crucial to abstinence from alcohol and other drugs (Hsu et al., 2013).

A study by Daughters, Lejuez, Kahler, Strong, and Brown (2005), which examined 89 substance users, measured dysphoria, anxiety, frustration, difficulty concentrating, and irritability (measured on a 100 point Likert scale) while completing a psychologically stressful task (the Paced Auditory Serial Addition Task). Participants were given a standard questionnaire prior to engaging in the task which included a question on length of abstinence. Although they completed the questionnaire, 73% of the participants, who were randomly selected, terminated the task before the maximum allowable time was elapsed. Results indicated that there was a positive relationship between length of abstinence and persistence in completing the psychologically stressful task. Most noteworthy was the finding that longer periods of abstinence correlated with higher levels of persistence. No other variable, including level of skill, significantly correlated to length of abstinence. The study supports the positive role of distress tolerance in successfully completing psychologically challenging tasks (Daughters, Lejuez, Kahler, et al., 2005).

It may be argued that recovery from a substance abuse disorder is a psychologically challenging task and that cultivating distress tolerance increases an individual's chances of

sustained recovery. Additionally, the above definitions suggest that a modicum of self-regulation, which begins with the ability to productively manage automatic mental responses to perceived distress or need, is necessary to produce desired outcomes in recovery. Therefore, recovery modalities must include coping skill development for urges, craving, and distress tolerance. Consequently, coping skills development couched within various definitions of recovery as well as thorough examinations of recovery models, orientations, and approaches are detailed below.

Recovery

Definitions of Recovery

Whereas definitions of the interrelated concepts of addiction, craving, and distress tolerance are reasonably well defined, there is no consensus on a definition of recovery in the field of addictions. Caroll and colleagues (2014) stated that the substance abuse recovery field has come to no agreement on the establishment of applied, quantifiable, or clinical indices for success, and universally accepted measures of success for recovering from drug use are elusive. White (2007), indicates, even though the term recovery clearly refers to a return to health in the medical field, there is a lack of accord in the substance abuse treatment field as to when substance abuse recovery is accomplished, lost, or re-established. The Betty Ford Institute Consensus Panel (Betty Ford Institute Consensus Panel [BFICP], 2007) stated there is no clear public conception of substance abuse recovery, nor is there concurrence among treatment professionals, and well-established theoretical formulations of recovery often do not share underlying conceptual structures or measurements. Dodge, Krantz, & Kenny (2010) also assert that not only is there no consensus across disciplines for a definition of substance abuse

recovery, there is an absence of real agreement amongst substance abuse professionals themselves.

That said, some working definitions were offered for critical review and research, or as guidelines for eventually developing an understanding of substance abuse recovery. The BFICP (2007) offered that recovery is not simply sobriety, but encompasses a personal condition which entails wellness, quality of life, and improved function. Also, according to the BFICP (2007) successful recovery may be assessed by three criteria, which include sustained sobriety, good personal health, and community engagement. Dodge and colleagues (2010), conceptualize recovery as a continuum of change and growth. Rather than setting criteria, however, they offer working domains that include physical health, biomarkers (biological measurements of events or processes in the body), extent of chemical dependency, presence of co-morbid psychiatric disorders, family and social engagement, and spirituality (Dodge et al., 2010).

The Harm Reduction Coalition (Harm Reduction Coalition [HRC], 2015) defines recovery through eight tenets that empower individuals to improve overall wellness. These tenets are: acceptance of the reality of drug use in the world, complexity of drug use modalities, emphasis on quality of life, non-coercion, drug users voice in the process, drug users as primary agents of change, reality of social injustice and, avoidance of downplaying or minimizing the harmful impact of illicit drugs. Finally, Tiffany and colleagues (2012) provide five outcomes for substance abuse treatment: change self-efficacy, psychosocial functioning, social support, reduction of craving, and improvements in quality of life. Taken together, the overall impression gained from the these sources is that quality of life, well-being and health, and improved social function and community engagement are integral to a definition of recovery.

Interestingly, discontinuation of substance use is a goal in recovery; however, complete abstinence is down played in the literature as a predictor for successful outcomes. Caroll and colleagues (2014) state that change is dynamic and limiting success in recovery to full abstinence may be an unreasonable and exclusive bench mark. Tiffany and colleagues (2012) assert that reduction of craving has significance in recovery, but complete abstinence is secondary to reduction of the consequences of drug use in predicting positive outcomes. White (2007) stated that discussions of recovery that focus exclusively on abstinence ignore the enmeshed contextual matrix in which substance use occurs. HRC (2015), while valuing drug use cessation as the best practice, places emphasis on helping professionals meeting those individuals using drugs where they are in their substance use patterns and addressing the conditions for use. These positions on abstinence are in accord with Croff and colleagues (2014) who, describing culturally competent practice for Alaska Native and American Indian populations, state that interventions should focus on reintegration and rebalancing of the individual in the community. In sum, a unified definition of recovery is absent from the field of addiction, which is intuitive given the complex nature and unique considerations that must be taken into account when extinguishing, overcoming, reducing, or managing an addictive behavior.

Recovery Models, Orientations, and Approaches

Given the lack of consensus in the field, it is not surprising that a plethora of traditional and contemporary models, orientations, and approaches to recovery exist. The following exploration of recovery models is limited to the Minnesota and Harm Reduction models, approaches based on a CBT orientation, and Mindfulness approaches, as these provide the theoretical underpinnings to the urge surfing intervention for managing urges, cravings, and withdrawal related distress. The Minnesota/ Disease model, which advocates abstinence-only in

recovery, is a progenitor of biological, cognitive, and behavioral conceptualizations of addiction (Henninger & Hung, 2014). Through its insistence that addiction is a disease of the brain, the Minnesota/ Disease model ultimately paved the way for an understanding that cognitive and behavioral processes are central to recovery (Henninger & Hung, 2014). The Harm Reduction model, which eschews abstinence only for a graduated substance use reduction approach, provides a rationale for refocusing recovery efforts away from a results based orientation, and towards the factors that fuel withdrawal distress, urges, and cravings (HRC, 2015).

Recovery approaches based on the CBT orientation, including the Relapse Prevention and MBRP approaches, negotiate the middle ground between the extremes of abstinence only and Harm Reduction as they can be applied regardless of model. CBT considerably refines the understanding of the sequence of cognitive processes, and creates a framework for identifying automatic mental responses, such as urges and cravings, and their subsequent impact on actions and behaviors (Witkiewitz et al., 2005). Mindfulness based approaches take advantage of, and expand the CBT framework, and place a central focus on automatic mental processes as the impetus for actions and behaviors (Beckstead, Lambert, DuBose, & Linehan, 2015; Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013; Ostafin & Marlatt, 2008; Turner, Welches, & Conti, 2013).

Minnesota/ Disease Model

The Minnesota/ Alcoholics Anonymous (AA)/ Disease Model is based on a medical model of addiction and 12-Step AA principles (Henninger & Hung, 2014; Mckay & Hiller-Sturmhofel, 1999). This model was created in the 1950s by the Hazelden Foundation and remains a prevalent, even pervasive, approach to facilitating recovery from substance use disorders (Henninger & Hung, 2014). The Minnesota Model focuses on chemical dependency,

identifies addiction as a disease of the brain, and uses a number of interventions to resolve that problem. Possible interventions include the use of a Twelve Step program with attendance at AA meetings, group therapy, lectures, professionalized persons in recovery, multi-disciplinary staff, a therapeutic milieu, family counseling, therapeutic work assignments, daily reading (Twelve Step literature), presentation of a life history, and opportunities for recreation/physical activity (Guthman, Sandberg, & Lybarger, 1999).

The Minnesota Model has evolved as the field of substance abuse recovery has progressed and is now integrated into a flexible part of a continuing care progression (Henninger & Hung, 2014; Mckay & Hiller-Sturmhofel, 1999). The Minnesota Model is foundational to what may be discerned as mainstream residential treatment program infrastructure, and it is a major contributor to current forms of both residential treatment and community based sobriety groups such as AA or Narcotics Anonymous (Henninger & Hung, 2014). It is a driver of the abstinence-only construct for recovery (Guthman et al., 1999; Henninger & Hung, 2014). With its emphasis on chemical dependency as a disease of the brain, the Minnesota Model opened the door for empirically supported orientations and approaches such as CBT, Relapse Prevention, and Mindfulness. This integration eventually yielded a greater awareness of automatic mental responses such as urges and cravings, and the role of diminished distress tolerance in precipitating those troublesome responses.

Harm Reduction Model

The Harm Reduction model of recovery focuses on both the factors surrounding substance abuse and on reducing the negative consequences of substance use, rather than insisting on abstinence (Guthman et al.,1999; HRC, 2015; World Health Organization [WHO], 2006). These two focal points reduce potential stimulus for the impetus (strong urge) to persist in

harmful behavior. While Harm Reduction does not hold abstinence-only as a principle, the perception that Harm Reduction is in opposition to abstinence-only modalities is not accurate. Harm Reduction is founded on a premise that change is more manageable if done gradually (WHO, 2006). Harm Reduction operates on a hierarchy that acknowledges the dynamic continuum of change in the world of a person who uses illicit substances, and gives abstinence priority as the best approach (WHO, 2006). Specifically, participants are first encouraged to be abstinent, if possible or likely. Then, discontinuation of hazardous practice such as injection is encouraged. If injection is unavoidable, safe use habits are encouraged, including use of sterile equipment, or use of bleach to clean equipment between uses (WHO, 2006).

Harm Reduction accepts the frank reality that some individuals using drugs are not capable of cessation without chemical augmentation and ultimately seek to minimize negative consequences as their primary goal (WHO, 2006). Harm Reduction advocates have been the primary drivers of controversial approaches such as safe needle exchanges and medication assisted treatment, for instance the methadone maintenance programs for people recovering from heroin addiction (Guthman et al., 1999). According to the HRC (2015), some tenets of Harm Reduction are that drugs are a part of life, drug use is a complex issue that exists on a continuum of use, quality of life is paramount, and intervention should be non-judgmental and non-coercive. Furthermore, Harm Reduction purports that people in recovery should have a voice, and asserts they are the primary agents of change. This model acknowledges that social injustice and inequality are factors in recovery, and downplaying the harm of illicit drugs is unsupportable (HRC, 2015). Through adherence to a focus on mediation of the external and internal factors that stimulate an impetus or powerful urge to engage in harmful, substance abusing behavior, the

Harm Reduction model essentially establishes that it is imperative that both stressors and automatic mental responses must be managed if a recovery effort is to be effective.

Cognitive Behavioral Therapy

Although it is often found in conjunction with the Minnesota/ Disease model, CBT occupies the ground between the abstinence only and Harm Reduction models, as adherence to either extreme is not a component of its theoretical structure. (Guthman et al., 1999). CBT, which is not specific to substance abuse recovery in its original conception, is well studied and has received a great deal of empirical support (Arch et al., 2012; Witkiewitz et al., 2005). CBT based approaches focus on identifying dysfunctional beliefs which are triggered by an internal stimulus and an external cue, which in turn will activate an automatic thought, leading to craving (Darbeda, Carre, Orri, Barry, & Lejoyeux, 2015).

CBT based programs typically involve group work, development of relapse prevention planning, and behavioral and coping skills for positive response to substance use triggers (Guthman et al., 1999; Stappenbeck et al., 2015). A specific focus of CBT based programs is to assist people in recovery with identifying high risk situations and learning to either avoid or change their relationship to them through functional coping. CBT based programs are characterized by development of skill in recognizing craving, managing thoughts and thought stopping, problem solving, refusal skills, exploration of cognitive substance use patterns, identification of high risk situations, and experiential skills practice (Guthman et al., 1999). With the CBT orientation, recognition of the import of managing automatic mental responses begins to coalesce into what will eventually become a central feature of Mindfulness approaches.

Relapse Prevention Approach

In a recently published survey on government supported evidence based programs implemented for American Indian and Alaskan Native populations, it was determined that a majority of treatment providers found Relapse Prevention and Motivational Interviewing to be the only two, out of multiple evidence based models, that were culturally aligned (Novins, Croy, Moore, & Rieckman, 2016). The Relapse Prevention approach applies CBT theory to recovery therefore it utilizes a similar albeit expanded behavior chain which incorporates elements such as effective or ineffective coping strategies, appraisals, and perceptions about self-efficacy that can perpetuate lapse and relapse (Darbeda et al., 2015; Larimer et al., 1999; Witkiewitz et al., 2005). In conjunction with use of the enhanced behavior chain, Relapse Prevention seeks to identify and remediate cognitive deficits in coping skills, as well as increase self-efficacy in problem solving, while challenging erroneous assumptions about substance use related outcomes (Larimer et al., 1999; Witkiewitz et al., 2005). The Relapse Prevention approach elevates concern for management of automatic mental responses. Subsequently, interventions which employ both cognitive visualization strategies and behavioral non-reactivity strategies, in combination with aspects of mindfulness, such as focused concentration and awareness are encouraged to develop skills for coping with urges, craving, and temptations (Witkiewitz et al., 2005).

Mindfulness Approaches

Mindfulness approaches have become prevalent in the substance abuse field. Mindfulness emphasizes acceptance and non-judgmental awareness as a means of mitigating motivators such as craving, urges, and temptations (Himelstein, 2011). According to Witkiewitz and colleagues (2005), neurobiological research supports the hypothesis that meditation and mindfulness cultivates metacognitive insight and the development of alternatives to automated or impulsive

behavior. In addition to these findings, mindfulness approaches seek to find a balanced midway between harmful levels of use and extreme forms of abstinence (Bowen et al., 2011). In as much as they do not explicitly insist on abstinence only, mindfulness models may be categorized as a part of the harm reduction continuum.

Mindfulness approaches are characterized by development of awareness, acceptance of experiences and environmental phenomena, clarification of values and beliefs, and establishing congruence by living in subsequently value informed ways (Turner et al., 2013). Awareness, a metacognitive activity which may be defined as maintaining one's attention in the present moment, without attempting to control the experience, is particularly important in Mindfulness models (Turner et al., 2013). The function of developing awareness without control is to foster a capacity for releasing avoidant behaviors - a means of controlling the immediate and unpleasant experience - that support addiction (Turner et al., 2013).

Automatic mental processes are a central concern of Mindfulness approaches (Ostafin & Marlatt, 2008). Acceptance based intervention moderates the effect of automatic mental process on behavior through non-reactivity, which changes the relationship with internal experience as opposed to changing the experience (Hayes et al., 2004; Ostafin & Marlatt, 2008; Ostafin, Bauer, & Myxter, 2012; Witkiewitz, Bowen & Donovan, 2011). In a study of the relationship between automatic alcohol processes and heavy drinking, Ostafin and colleagues (2012) employed an Implicit Association Test, which measure the strength of association between concepts or constructs - to demonstrate that those in the mindfulness based participant group evidenced a weaker relation between automatic alcohol processes and heavy drinking compared to the control group which received no mindfulness training.

Examples of Mindfulness approaches are Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT). The aim of ACT is to produce psychological flexibility through a combination of mindfulness modalities, such as non-reactive acceptance and commitment to behavior change processes (Arch et al., 2012; Hayes et al., 2013). ACT is founded in functional contextualism, which emphasizes psychological activities as being a result of the whole person's interaction with their situationally or relationally defined contexts (Biglan & Hayes, 1996). ACT guides the client to accept contextual/ relational factors that are out of an individual's control and to address functional factors defined as the manner in which relational information is perceived and implemented intellectually and emotionally (Biglan & Hayes, 1996). According to Hayes, Luoma, Bond, Masuda, and Lillis (2006), ACT seeks to change both the function of internal psychological events and an individual's relationships with them, as opposed to using more avoidant strategies, or attempting to change the events themselves.

Like ACT, DBT is an evidence based practice that emphasizes mindfulness as a core practice or skill (Beckstead et al., 2015). Corey (2013) states that DBT uses cognitive and behavioral analytical techniques in combination with Buddhist influenced mindfulness, which includes awareness in the moment, non-judgmental acceptance, non-attachment, and clear perceptions of reality. A key task of DBT is to acknowledge and accept the existence of dialectical or opposing forces that occur simultaneously in the client's life (Corey, 2013). DBT targets substance use behaviors in a hierarchical fashion reminiscent of hierarchy of needs models of human development (Beckstead et al., 2015). Survival and preservation of life are addressed first. Behaviors related to treatment are addressed second. Behaviors related to life function and quality of life are addressed third (Beckstead et al., 2015).

Multicultural Competence and Mindfulness Approaches. Aside from being a defining factor in the overall competence of services, and being ethically mandated, multicultural appropriateness is also necessitated by demographic factors in the United States and Alaskan treatment environments. The National Survey on Drug Use and Health (SAMSHA, 2012) states that between 2003 and 2011, 17% of American Indian and Alaska Native people required treatment for substance abuse in the previous year, as opposed to 9.3 % of other ethnic or racial groups. Within the population receiving treatment for substance abuse, 15 % of American Indian and Alaska Native individuals received specialty treatment for substance abuse, compared to 10.2 % of people from other ethnicities and races. The Center for Behavioral Health Statistics and Quality (SAMSHA, 2014) reports that 45.4 % of the total admissions for substance abuse treatment in Alaska in 2015 was compromised of individuals identifying as American Indian and Alaska Native, compared to 33.8 % identifying White, 1.6 % African American, 1.1 % Asian, Native Hawaiian, or Pacific Islander, and 18.1 % other or unknown.

Given the prevalence of American Indian and Alaska Native populations engaging in substance abuse treatment programming, both nationally and in Alaska, it is imperative that an intervention be congruent with contemporary American Indian and Alaska Native needs. Unfortunately, there are barriers to meeting those treatment needs such as a multitude of socioeconomic, cultural, and historical factors, which are further exacerbated by historical trauma and on-going marginalization by the majority culture. As an example of marginalization, Legha, Raleigh-Cohn, Fickenscher, and Novins (2014) indicate that there is a direct disparity of committed resources, with American Indian and Alaska Native communities receiving a disproportionally smaller amount of funding support and services than the rest of the country. Limitations in resources contribute to a frustrating array of economic impediments to clinical

support, infrastructure, and delivery of service, including childcare issues, lack of transportation, understaffing, poor facilities, lack of training, or a simple lack of office supplies (Legha et al., 2014).

In addition to marginalization from outside American Indian and Alaska Native communities, there is distrust towards evidence based practices from within these communities (Novins et al., 2016). Evidence based practices are often perceived as not being developed for, or tailored to, the realities experienced by American Indian and Alaska Native treatment populations, and as being directly oppositional to Indigenous sovereignty (Croff et al., 2014; Novins et al., 2016)). Such misgivings are understandable, as imposed outside approaches are reminiscent of the historically tense relationship between American Indian and Alaska Native peoples and government agencies (Croff et al., 2014; Legha et al., 2014). Ill-informed and abusive policies from governmental entities have been, and continue to be the cause of considerable intergenerational trauma (Croff et al., 2014). The response to this concern from the therapeutic community has been the emergence of evidence based culturally relevant substance abuse treatment modalities which are either tailored to, or designed with and for American Indian and Alaska Native communities (Croff et al., 2014).

As an example of a tailored approach, Beckstead and colleagues (2015) speculate that given most spiritual traditions have some type of mindfulness component to them, such as prayer, meditation, or ritual, DBT and mindfulness models can provide a bridge between evidence based approaches and traditional practices in a cross cultural context. Towards that end, a study was conducted with 229 American Indian youth, representing 39 tribes, in a youth residential treatment facility (Beckstead et al., 2015). It was found that DBT addiction skills in conjunction with traditional medicine practices, conducted with a cultural consultant (a medicine

man) providing clinical services, contributed to significant clinical change for participants (Beckstead et al., 2015). Clinical change over time was found to be significant with 96% of participants showing positive outcomes at the time of discharge (Beckstead et al., 2015). This study suggests that mindfulness models and interventions may prove to be culturally competent approaches appropriate to programs serving American Indian and Alaska Native populations.

Mindfulness-Based Relapse Prevention

Mindfulness-Based Relapse Prevention (MBRP) is an approach that combines CBT based Relapse Prevention with a Mindfulness focus on distress tolerance, urges, and cravings (Khanna & Greeson, 2013). Metacognitive practices, which mindfully observe the mind, are applied in an effort to enhance CBT interventions for substance use behavior through focus, concentration, and non-judgmental, non-reactive awareness (Witkiewitz et al., 2005). According to Witkiewitz and colleagues (2005), "the goal of this relapse prevention method is to develop awareness and acceptance of thoughts, feelings, and sensations through practicing mindfulness, and to utilize these mindfulness skills as an effective coping strategy in the face of high risk situations" (p. 221). As such, a core component of this intervention is the development of internal awareness and the utilization of this awareness to more effectively cope with high risk high stress situations which place sobriety at risk.

MBRP specifically targets urges and cravings, as success in redefining the relationship with urges and cravings increase an individual's self-efficacy in regards to self-regulation (Witkiewitz et al., 2013). Mindfulness practice brings awareness and non-judgment to the transient impermanent state of craving, so that it can be experienced in a way that does not fuel addictive behavior (Witkiewitz, Bowen, et al., 2014; Witkiewitz et al., 2005). Progressive skill

building in non-responsive and non-judgmental observations of craving increases tolerance to the distress it typically causes and reduces negative affective reactivity to it (Witkiewitz et al., 2013).

In addition to addressing craving, MBRP practices are intended to increase tolerance of any negative mental, emotional, and physical states that may typically be a cause for coping through avoidance (Witkiewitz et al., 2013). MBRP seeks to shift away from accepting a causal and impulsive relationship between emotional discomfort and automated behaviors such as avoidance through substance use. This shift is accomplished through developing an individual's relationship with distress, again by employing awareness and non-reactivity, and reducing the power of that distress through familiarization and extinction (Gregoire, 2015). A change in the way one relates to distress is also achieved through establishing the impermanence of negative and positive states (Gregoire, 2015). Undermining the substantiality of negative and positive affective states defuses them from automatic mental processes, such as urges or cravings, and reduces the potential of substance use as a coping behavior (Khanna & Greeson, 2013; Witkiewitz et al., 2013).

Grow, Collins, Harrop, and Marlatt (2015) state that participation in MBRP increased the likelihood of developing auxiliary practices, such as an MBRP based mindfulness practice at home, which produced positive outcomes during treatment. Hsu and colleagues (2013) found that individuals with low distress tolerance, who received MBRP, had an initially lower use of alcohol and other drugs at follow up, as relative to receiving treatment as usual. Witkiewitz and colleagues (2014) established moderate support for MBRP efficacy as a substance abuse intervention when compared to treatment as usual for substance dependent incarcerated women. Bowen and colleagues (2014) discovered that MBRP resulted in a delay of relapse up to six months after termination of treatment with a reduction in the quantity of use and heavy drinking

days at a 12 month follow up. Bowen and colleagues (2009) showed that MBRP reduced the numbers of days that clients used alcohol or illicit drugs, as compared to those clients receiving treatment as usual.

As can be seen, management of distress and automatic mental responses, such as urges and cravings, is integral to effective recovery strategies regardless of model, orientation, or approach. Definitions of addiction invariably indicate that urges, craving, temptation, or other such automated behaviors are major reinforcing factors. Given that management of urges and cravings, as well as development of distress tolerance are viewed as critical to recovery, it is incumbent that substance abuse recovery programming incorporate an intervention that directly develops client self-efficacy and skill in this area.

MBRP Urge Surfing

In an on-line discussion of MBRP, Dr. G. Alan Marlatt said, "Buddhist understanding of urges and cravings is that you can't get rid of urges and cravings. You have to learn some sort of acceptance. Then you can ride them out. You can let them go without giving in…" (Griffin, 2010). Urge surfing is a popular and well known cognition based urge and craving management technique typically integrated into larger therapeutic programs (O' Donohue & Fisher, 2009). An Internet search of the term "urge surfing" will yield approximately 530,000 search results. Although there are a significant number of search results on the Internet, the number of peer reviewed research articles and studies are sparse and tend to orient around a small number of authors involved in mindfulness based mental health and addictions research and treatment.

The urge surfing intervention. The concept of urge surfing was created by Dr. G. Alan Marlatt as a skillful cognitive and behavioral means to weaken addictive conditioning and facilitate acceptance and self-efficacy (Witkiewitz et al., 2005). Urge surfing is used to develop

skill in coping with cravings and urges that may instigate substance use or relapse (Bowen et al., 2011; Turner et al., 2013). Cognitive urges may arise from any number of stimuli including autonomic nervous signals, environmental cues, substance abuse withdrawal, negative affect, expectations, substance availability, or neurologically based substance use cues (Witkiewitz et al., 2005). Urge surfing is grounded in mindfulness (focused concentration), cognition (visualization), and behavior (non-reactivity) based modalities of recovery (Witkiewitz et al., 2005).

MBRP urge surfing develops a sustained, creative visualization that triggers the urge or impulse to use a substance of addiction. Clients are encouraged by a facilitator to visualize a moderately high risk substance using scenario until it triggers a craving or impulse. Participants are then instructed to observe the craving or impulse as if it were a wave, maintaining awareness of the wave with as little reactivity or judgement as possible, eventually allowing it to subside on its own. Participants are encouraged to surf or be with this wave and ride out the intensity of it as a way to lessen resistance or reactivity (Bowen et al., 2011; Dharmadikiri & Sinha, 2015; Turner et al., 2013).

In conjunction with the mindfulness and visualization component of urge surfing, a brief explanation of the utility of exposure to and acceptance of cravings and impulses in recovery may be provided to participants (Bowen et al., 2011). Additionally, the facilitator will process participant's immediate experiences with cravings and urges, and any associated affective content or schemata, such as a desire to fix, avoid, or change reactions or emotional states (Bowen et al., 2011). Like the mindfulness and visualization component, the objective of the explanation and process is to provide an experience of being with cravings and urges without

judgement, thereby decreasing reactivity, negative self-appraisal, and decoupling urges and cravings from automatic or habitual action (Bowen et al., 2011).

Urge surfing evidence. A small number of studies can be examined in order to explore the effectiveness of urge surfing. For example, Ostafin and Marlatt (2008) concluded that in the relationship between automatic alcohol motivation and dangerous drinking, non-reactive acceptance and observation moderated the effect of automatic alcohol motivation on hazardous drinking. This result emerged from a test of 50 college students using an Implicit Association Test and regression analysis. The Implicit Association Test measures the strength of associations between concepts. In explaining these results, the authors speculate that experiential acceptance decoupled 'automatic appetitive responses and actual behavior', creating space between cognition and behavior, leaving room for the development of more functional coping (Ostafin & Marlatt, 2008).

In another study, Bowen and Marlatt (2009) examined application of urge surfing in a smoking cessation study and found the urge surfing group showed a significantly weaker connection between negative affective states and the urge to smoke than members of the non-urge surfing control group. Further, over the seven days following the experimental sessions, participants in the urge surfing group demonstrated a 26% decrease in cigarettes per day (1.55 fewer than baseline), as opposed to an 11% decrease in cigarettes per day (.53 fewer than baseline) in the control group (Bowen & Marlatt, 2009). Results from this study suggest that even brief urge surfing instruction can be helpful in changing smoking behavior (Bowen & Marlatt, 2009).

Taken together, these studies suggest that the skill of urge surfing is an ideal intervention for interrupting automatic addictive response by decreasing the process of automatic reactivity,

thus allowing time for rational problem solving and the implementation of values and belief based decision making. In doing so, the skill of urge surfing may thereby decrease relapse potential. Given its efficacy in short term studies and its immediacy in application, urge surfing is particularly suited to early recovery populations seeking treatment in short term residential settings.

Cultural values and the applicability of urge surfing. At face value, MBRP urge surfing appears to be congruent with Alaska Native traditional values and concepts of personhood. More specifically, common values for Inupiat and Yup'ik people often include, among others, patience, endurance, avoidance of conflict, humility, cooperation, accepting life's challenges, learning to manage stress, and determination (Alaska Native Knowledge Network, 2006; Hazel and Mohatt, 2001). For, Athabascan people, cultural values include self-sufficiency, hard work, honesty, fairness, and humor (Alaska Native Knowledge Network, 2006). The values of Tlingit people include physical and inner strength, and adaptability to change while maintaining cultural integrity (Cheney, 2014). The Alaska Native Knowledge Network (2006) also provides an overarching set of pan-Alaska Native values that includes accepting what life brings, having patience, and praying for guidance. In each of these sets of values, development of distress tolerance, non-impulsivity, acceptance, and willpower are either in accord with or epitomize the traditional worldview.

In addition to accordance with American Indian and Alaska Native values, the urge surfing technique appears to align well with Indigenous ways of learning and knowledge. According to Deloria Jr. (2012), the American Indian person "confronts the reality of existence" in an experiential manner that "is not limited by mental considerations or assumptions regarding the nature of the universe" (p. 5). Urge surfing, specifically, and mindfulness approaches in

general, mirror this direct engagement with experience, unencumbered by modifying concepts, perceptual filtering, or judgement.

Further, Gone (2009) indicates that American Indian learning is characterized by hands on experience, and knowledge is grounded in real life contexts and is temporally oriented on the present. Barnhardt and Kawagely (2005), reflecting more specifically on Alaskan Native people, state that direct experience is the pathway though which knowledge is typically acquired by Indigenous people. The very nature of the urge surfing intervention is direct, immediate, experiential, and confronts the reality of the moment, because urges and cravings are immediate in nature. This alignment of the nature of urge surfing with Indigenous ways of learning and knowledge supports an argument for at least collaboration, if not for a direct application of the intervention with American Indian and Alaska Native populations.

It should be observed, however, that given the history of the American Indian and Alaska Native experience with government agencies, which includes subjection to boarding schools, direct and overtly genocidal government policy, and on-going discrimination and marginalization resulting in extensive intergenerational historical trauma, and subsequent distrust, it is not sufficient to develop an intervention at any level without local cultural consultation (Croff et al., 2014; Dickerson, Venner, & Duran, 2014; Legha et al., 2014; Novins et al., 2016). As demonstrated by Beckstead and colleagues (2015), a productive collaboration is possible, but the effort must produce more than a simple introduction of effective interventions. The effort must involve the larger social aims of decolonization and the promotion and support of Indigenous sovereignty if it is to ameliorate the effects of historical trauma on the recovery process (Gone, 2009).

Psychomotor and Cognitive Interference with Cognition Based Approaches

Important to an understanding of urge surfing is that it was developed for recovering populations engaged in post-treatment, aftercare settings (Bowen et al., 2011). Aftercare is the lowest level of care after diversionary alcohol and drug education or 12-Step support, and it typically occurs after acute and post-acute withdrawal symptoms have diminished or become manageable. However, in early recovery or residential higher level of care settings, acute and post-acute withdrawal symptoms can potentially provide a considerable barrier to participation in the urge surfing exercise. Specifically, withdrawal related deficits in cognition may prove obstructive to a client's ability to engage the visualization component of the technique (Manning et al., 2008; Narayanan et al., 2012; Niikura, Zhou, Ho, & Kreek, 2013; Wollenweber et al., 2014). Recall that the visualization in urge surfing requires a client to imagine a high risk substance use scenario until an urge to use alcohol or drugs is produced. Below is a description of the post-acute symptomology typically experienced in early recovery or higher level of care settings, which poses significant challenges to clients

Alcohol, Benzodiazepine, and Sedative Withdrawal

Long term alcohol consumption results in disruption and suppression of gamma-Aminobutyric acid (GABA) levels which are instrumental in moderating neuronal sensitivity and receptivity (Liu & Wang, 2013). Abstinence from alcohol initially leads to hyperarousal or hyper-excitation until GABA levels return to normal (Liu & Wang, 2013; Nayak et al., 2014; Pizon, 2015). Acute withdrawal from alcohol, which may occur for up to seven days from initial abstinence, can include insomnia, craving, visual or auditory hallucinations, tonic-clonic seizures, delirium tremens, anxiety, inattention, and disorientation (APA, 2013; Freeman et al., 2012; Pizon, 2015; Rogawski, 2005). Post-acute withdrawal from alcohol, which may extend

past the time frame of many residential treatment programs, may include symptoms such as dysphoria (a general feeling of unease), anergia (a lack of energy), tremors, disturbances in mood, irritability, craving, anxiety, insomnia, dysregulation of the autonomic nervous system, and it may also include changes in consciousness, global confusion, and cause disorientation (Perney, Lehert, & Mason, 2012).

Sleep disturbance, experienced by up to 91% of people recovering from alcohol abuse or dependence, may last for up to two years from initial abstinence (APA, 2013; Perney et al., 2012). Prolonged use of alcohol results in structural damage to the frontal lobe, amygdala, cerebellum, and limbic system, primarily through glutamate related toxicity, but also from the above mentioned disruption of GABA (Liu & Wang, 2013). Cognitive impairment in the first six weeks of recovery can include challenges to executive functioning, such as problems with planning and consequential thinking, impulse control, visuospatial ability (the capacity to identify the relationship between objects or to imagine objects), attention, memory, and abstract problem solving tasks (George et al., 2012; Manning et al., 2008; Wollenweber et al., 2014).

Benzodiazepines and other sedatives function similarly to alcohol in the brain and the body (APA, 2013). Therefore, acute withdrawal from benzodiazepines and other sedatives is almost identical to alcohol. Withdrawal symptoms may not occur for a week from initial abstinence, may peak at two weeks, and they can last for an unspecified time frame (APA, 2013). Many of these post-acute withdrawal symptoms are obstructive to cognition based interventions; or, in other words, they will be too distracting for a client to focus on abstract activities.

Opioid Withdrawal

The acute phase of opioid withdrawal can last 5-7 days and may include symptoms such as dysphoric mood, craving, cramping, muscle aches, nausea, chills, insomnia, anxiety,

restlessness, and irritability (APA, 2013). Post-acute withdrawal symptoms may last from weeks to months and can include anxiety, dysphoria, hyper-activation of the sympathetic nervous system (APA, 2013; Niikura et al., 2013), craving (Schauss, 2012; Schmidt et al., 2014), inability to experience pleasure (anhedonia), and insomnia (APA, 2013). Negative affective and physiological withdrawal symptoms can lead to conditioned place aversion for specific environments or somatic locations associated with a negative reward, which can lead to somatic dissociation (Niikura et al., 2013). Prolonged heroin withdrawal can also induce deficits in sociability and increases in social avoidance at four weeks of abstinence that are distinguishable from, and co-occurring with conditioned place aversion (Lutz et al., 2014). There is little in acute and post-acute opiate withdrawal that will not disrupt a client's ability to focus on abstract cognition based therapeutic interventions.

Stimulant Withdrawal

Acute and post-acute withdrawal from stimulants may begin within two days of abstinence and persist for weeks past the time frames of many residential treatment programs (APA, 2013; Buffalari, Baldwin, & See, 2012). Acute withdrawal from stimulants (such as cocaine or methamphetamines) may include dysphoria, craving, fatigue, vivid unpleasant dreams, sleeplessness or excessive sleeping, increased appetite, and psychomotor retardation or agitation (APA, 2013; Buffalari et al., 2012). Early cocaine withdrawal symptoms may include anxiety, stress, and a range of language and cognitive impairments, including reduced cognitive flexibility (Narayanan et al., 2012). Post-acute methamphetamine withdrawal is characterized by impulsivity, cue induced craving, and mood disturbances such as depression and anxiety (Wang et al., 2013). It is apparent that each of these withdrawal symptoms will interfere with a client's ability to engage an abstract cognition based therapeutic intervention.

Cannabis Withdrawal.

Acute withdrawal from cannabis, which may occur between 24-72 hours from last use can include sleep difficulty, decreased appetite, restlessness, depressed mood, craving, yawning, fatigue, difficulty concentrating, hypersomnia, and increased appetite (APA, 2013). Cannabis withdrawal symptoms can last up to two weeks (APA, 2013), compromising a significant amount of treatment time in a residential program. As with the acute and post-acute withdrawal symptoms that result from abstinence from other substances, these withdrawal symptoms similarly provide potential obstruction to focus and concentration on an abstract cognition based therapeutic intervention.

To summarize, difficulties in planning, consequential thinking, impulse control, visuospatial ability, concentration, and other symptoms, including sleeplessness and restlessness, may disrupt or limit the effectiveness of an abstract cognition based therapeutic intervention. Sustained visualization, a core component of urge surfing as implemented in MBRP, is an abstract activity that requires efficient cognitive function (Bowen et al., 2011; Manning et al., 2008; Witkiewitz et al., 2005). Lack of efficient cognitive function would appear to make urge surfing, and potentially other cognition based interventions, inaccessible to a person in acute or post-acute withdrawal, such as those in higher levels of care, depending on the severity of their condition. Given this level of interference from withdrawal symptomology, the question is then, how can urge surfing be adapted to acute or post-acute populations?

Somatic Adaptations to Urge Surfing

A solution is to shift the focus of the exercise from an abstract, cognition based, sustained visualization to an exercise focused on concrete and immediate somatic experience. In order to make the shift from visualization to a somatic focus, participants may be able to draw from a

naturally occurring and pre-existing somatic distress that is an aspect of acute and post-acute withdrawal. As described above, there are somatic symptoms related to autonomic nervous system withdrawal which present as physical agitation, jitters, muscle spasms, shakes, and restlessness (APA, 2013; Perney et al., 2012). These symptoms contribute significantly as triggers for negative affect, which motivates withdrawal avoidant behavior, stimulating craving, lapse, negative appraisal, and relapse (Larimer et al., 1999; Witkiewitz, Bowen, et al, 2014; Witkiewitz et al., 2005). Given the impact of somatic distress on affective states, it is feasible that clients experiencing post-acute withdrawal can take advantage of this already present, and mostly unavoidable, somatic distress to precipitate urges and cravings for use in mindfulness exercises and interventions. To put this plainly, switching from imagining a stressful situation to focusing on an existing physically stressful situation, in order to create an urge, can make urge surfing accessible to participants who have trouble with visualization.

There appears to be no research specifically related to adapting urge surfing by grounding it in immediate somatic cues or triggers. However, one study in the urge surfing literature points to evidence that contextual physical cues or triggers do act as a precipitant to urges and cravings. Bowen and Marlatt (2009) observed that immediate physical cues, such as opening a pack of cigarettes, placing a cigarette in the mouth, and bringing a lighter to the cigarette without lighting it, caused participants to experience increased urges to smoke during treatment. Not a surprising discovery, this observation supports a link between immediate physical cues and their ability to precipitate internal automatic processes such as urges or cravings. However, in order to find further supporting evidence for this shift in focus, it is necessary to look towards the practice of other somatically based interventions and their impact of relapse prevention and recovery skills.

Evidence for a Somatic Approach

Although research specific to urge surfing does not address the implementation of somatic distress as a trigger for urges or cravings, research into yoga based therapies does explore the use of induced immediate somatic distress to develop self-regulation, acceptance, and non-reactivity. It is time honored tradition in yoga systems that holding difficult poses, defined as doing something with your body that the mind does not want to do, builds acceptance and tenacity (Anderson, 2009). Specifically, difficult or challenging postures, or asana, are held by yoga practitioners "through the fluctuations of the mind" (Gard, Noggle, Park, Vago, & Wilson, 2014, p. 2). The efficacy of this traditional wisdom is reflected in the literature.

For example, practitioners of yoga who incorporate motionlessness in relation to physiological distress not only demonstrate a higher tolerance for pain, but tend to use non-avoidant strategies such as objectively observing pain or attending to intense sensations without reactivity (Schmalzl, Powers, & Blom, 2015; Wren, Wright, Carson, & Keefe, 2011). Additionally, yoga based interventions have been shown to help traumatized clients develop tolerance for physical and sensory experiences related to trauma, such as fear and helplessness, in a manner that is at least equivalent to established psychotherapeutic practice (van der Kolk et al., 2013). Further, guidance from a facilitator, who maintained focus on bodily sensations and a breath based regimen, provided much better therapeutic outcomes for traumatized individuals without the significant complications of affect and impulse regulation (van der Kolk et al., 2013). Also, the use of the physical postures of yoga based interventions are purported to be instrumental in providing a "present-moment somatic focal point that feels safe to trauma survivors who are overwhelmed by body sensations" (Spinazzola, Rhodes, Emerson, Earle, & Monroe, 2011, p. 5). In reviewing these assertions, an argument emerges for the use of

immediate somatic experiences towards developing self-regulation of the relationship between thoughts and emotions, automatic mental processes, and coping behavior in substance abuse recovery.

There is additional support for this argument in research presented by Jindani, Turner, and Khalsa (2015), who found that Kundalini yoga practice resulted in a reduction of post-traumatic stress disorder (PTSD) related aversive symptomology. Kundalini yoga incorporates posture, physical exercises, breathing techniques, and meditation (Jindani et al., 2015). As a result of this yoga practice, PTSD Checklist (PCL-17) scores were reduced for the yoga group from a mean of 59.5 before treatment to 41.8 after treatment, as compared to the control group score of 55.1 before and 55.4 after (Jindani et al., 2015). Likewise, Insomnia Severity Index scores decreased for the yoga group from a mean of 14.4 before treatment to 10.6 after treatment, as compared to the control group score of 16.1 before and 16.4 after (Jindani et al., 2015). In addition, Perceived Severity of Stress scores were lower for the yoga group, down from a mean of 24.9 before treatment to 12.4 after treatment, as compared to the control group score of 24.8 before and 21.6 after (Jindani et al., 2015). Lastly, both Positive and Negative Affect Scale scores improved at follow up for the yoga group. Scores for positive affect increased from a mean of 26.3 to 30.5, and scores for negative affect decreased from a mean of 24.2 to 19.0 (Jindani et al., 2015). By comparison, the control group showed a decrease in positive affect from a mean of 26.9 to 23.8, as well as a decrease in negative affect from a mean of 24.7 to 21.9 (Jindani et al., 2015). Additionally, anxiety dropped from a score of 9.4 to 5.7, and non-reactive focus showed a small increase from 18.2 to 21.1 (Jindani et al., 2015). Overall, this study suggest that somatically based interventions appear to demonstrate efficacy in the development of distress tolerance, a significant factor in addiction and relapse.

Further support is yielded by Curtis, Osadchuk, and Katz (2011) who found that after an eight-week regimen of yoga and meditation, participants experiencing fibromyalgia demonstrated decreased levels of stress induced cortisol, reduced pain, less catastrophizing, and enhanced pain acceptance. Results indicating reduction in cortisol, a stress induced steroid produced by the adrenal gland, were based on collection of salivary cortisol three times er day for the length of the study (Curtis et al., 2011). In essence, the reduction in stress induced cortisol demonstrated by this study is evidence that a therapeutic regimen based on somatic interventions reduced reactivity to physical distress. These findings are relevant to participants requiring high levels of care within residential treatment facilities and are experiencing acute and post-acute withdrawal symptoms.

Bond and colleagues (2013), added to this body of research when determining that 11 yoga classes augmented by home practice has a positive influence on participants. Results indicated that participant's perception of their stress level reduced from a mean of 1.55 to 1.48, self-regulation scores from 3.49 to 3.58, self-compassion scores from 219.9 to 225.5, and empathy levels from 2.88 to 3.25. Bock and colleagues (2012) produced positive results for 55 women participating in an eight-week smoking cessation group that employed either Vinyasa yoga or a general health and wellness program. In addition to reduced anxiety and improvements in perceived health, participants in the yoga group were found to have a greater prevalence of abstinence than the control group, and these positive results were sustained at a six-month follow-up (Bock et al., 2012). Together, these findings indicate that somatic interventions can have an impact on affective states and the development of self-regulation for clients in recovery.

Beyond overt behavioral outcomes, such as increased self-regulation or reduced catastrophizing, there is also evidence that change occurs at the neurobiological level which

underlays behavior necessary for resilient recovery. For instance, Streeter and colleagues (2007) found that GABA increased 27% after one hour of guided yoga and meditation performed by knowledgeable participants in a yoga based intervention, as compared to a control group which showed no change. The GABA system operates in the prefrontal cortex and is associated with willpower and impulse control (West, Liang, & Spinazzola, 2016). It is also a factor in reducing stress and anxiety and in increasing affect regulation (West et al., 2016). As noted above, alcohol and benzodiazepines directly affect GABA levels, and withdrawal from these substances can result in a lack of this chemical (Liu & Wang, 2013). Streeter and colleagues' (2007) study suggests that somatic interventions can have a direct influence on increasing individual willpower though stabilization of the GABA system.

Recovery and Somatic Interventions

Whereas somatic interventions have a demonstrated ability to improve self-regulation, and are shown to impact the physiological process of healing, a more specific concern is whether they can influence substance use recovery outcomes directly. In their study on the efficacy of yoga for women experiencing PTSD, Reddy, Dick, Gerber, and Mitchell (2014) found a trend towards lower rates of alcohol and drug use amongst participants who engaged the yoga based interventions, as opposed to the control group. Mean scores based on the Alcohol Use Disorder Identification Test (AUDIT) were 1.95 for the yoga group and 3.33 for the control group. Mean scores for the Drug Use Disorder Identification Test (DUDIT) were .85 for the yoga group and 1.17 for the control group. These results reveal that the yoga group demonstrated a decrease to 1.29 on the AUDIT, and a decrease to .07 on DUDIT. The control group demonstrated an increase to 4.18 on the AUDIT and a small decrease to 1.09 on the DUDIT. At a one-month follow-up, participants in the yoga based intervention group disclosed higher levels of symptom

management and showed more interest in pursuing other evidenced based therapies than the control group (Reddy et al., 2014). Furthermore, they demonstrated a sustained reduction in high risk drug using behavior (Reddy et al., 2014). These findings indicate that somatic interventions may positively influence recovery from substance use disorders.

The above yoga based intervention studies suggest that immediate somatic distress can be harnessed to facilitate neurological, cognitive, and behavioral change. It becomes plausible that a shift of focus, within the urge surfing exercise, from a purely cognitive activity, such as visualization, to a focus on a somatically based activity, such as remaining motionless and non-reactive, can similarly facilitate such change. This shift occurs while being physically agitated by withdrawal symptoms, and it can be a productive means of decoupling automatic mental processes from coping behaviors. More specifically, stillness can be juxtaposed with physical agitation to precipitate urges and cravings that can be used by participants in the urge surfing exercise.

This process is fully described in the description of the application. However, a snapshot of the exercise involves clients being encouraged by a facilitator to remain motionless in an upright posture and observe all physical sensations in their bodies until an urge or craving to fidget, move, or escape arises. Clients are then instructed to shift their attention from bodily sensations to the urge or craving and to maintain awareness of the rising, then falling, wavelike quality of the urge or craving with as little reactivity or judgement as possible, eventually allowing it to subside on its own. In the event that participants cannot shift their attention from bodily sensations, they may be instructed to observe those sensations non-reactively instead. In either case, participants are encouraged to surf, or be with the sensation or urge and ride it out as

a way to lessen resistance or reactivity (Bowen et al., 2011; Dharmadikiri & Sinha, 2015; Turner et al., 2013).

Description of Application

Urge surfing is a mindfulness method for decoupling automatic mental responses, such as urges and craving, from coping behaviors (Darbeda et al., 2015; Larimer et al., 1999; Ostafin & Marlatt, 2008; Witkiewitz et al., 2005). Through urge surfing, participants develop non-reactive acceptance to automatic mental responses, eliminating or reducing the need to cope with them (Bowen et al., 2011). The purpose of this application is to extend urge surfing to higher level of care for substance abuse recovery populations, whose presenting concerns include withdrawal symptoms, urges, and cravings.

Following detoxification, people seeking recovery typically receive residential substance abuse treatment, which subsequently occurs during acute and post-acute withdrawal (Acquavita et al., 2013). Speculatively, acute and post-acute withdrawal symptomology, invariable aspects of early recovery, can be obstructive to the visualization component that is necessary for execution of the urge surfing exercise (APA, 2013; Manning et al., 2008; Narayanan et al., 2012; Niikura et al., 2013; Wollenweber et al., 2014). The crux of this application involves visualization being replaced by a juxtaposition of rigorous stillness with the somatic agitation that is typically present as a result of acute and post-acute withdrawal (APA, 2013; Buffalari et al., 2012; Lutz et al., 2014; Perney et al., 2012).

This application provides a six session urge surfing group leader guide. Use of a progressive, multiple session format is necessitated by the impact of acute and post-acute withdrawal symptoms (described above) on cognition and attention, which may be most severe in the first week of treatment (APA, 2013; Buffalari et al., 2012; Freeman et al., 2012;

Narayanan et al., 2012; Pizon, 2015; Wang et al., 2013). Consequently, the first session's focus is on simple objectives involving exercises of an immediate and concrete nature. Later sessions include nuanced or abstracted activities. In the final two sessions, knowledge and experience acquired in this group is integrated into post treatment planning for relapse prevention, which is a speculative, abstract, and future oriented activity.

A group format for this application is preferred for a number of reasons. First, providing services in a group is a pragmatic use of time and energy, as it takes less effort to explain something once to ten people, than it does to explain something ten times (Ettin, 1992; Linehan, 2015). Second, groups offer clients the opportunity to interact with people like themselves resulting in validation, hope, bonding, and the natural development of a support group (Corey, Corey, & Corey, 2014; Ettin, 1992; Linehan, 2015). Third, groups provide an opportunity for peers to learn from each other, increasing therapeutic momentum and impact (Corey et al., 2014; Linehan, 2015). Fourth, groups are a natural laboratory for learning, rehearsing, and testing new adaptive skills, as well as developing peer related coping capacities (Corey et al., 2014; Linehan, 2015). Also, groups fit well within the managed care systems that dominate the mental health and substance abuse fields as they are cost effective (Corey et al., 2014; Ettin, 1992). In essence, the social energy of a group environment fosters exploration and integration of recovery concepts and skills, making it more likely that the skills will be utilized post treatment.

Each session of the application is composed of five parts: welcome, check-in, urge surfing, post urge surfing dialogue or process, and check-out. The welcome and check-in are common practice in a group structure and serve to encourage participant competence in group activities, cohesiveness within the group, and continuity from one group to the next (Corey et al., 2014). The urge surfing exercise at the heart of the session is derived from the format created by

Bowen and colleagues (2011) for MBRP, albeit with modifications of some core components. In the subsequent post-urge surfing dialogue, the facilitator guides an exploration of in-the-moment, direct experience from the urge surfing exercise using a collaborative turn-taking method of inquiry (Crane, Stanley, Rooney, Bartley, & Cooper, 2015; Piet, Fjorback, & Santorelli, 2016). Following the post urge surfing dialogue, common themes and participants' experiences from the urge surfing exercise are summarized for the whole group as part of the closing and check out. Also, included in the closing and check-out is an opportunity for participants to perform an informal scaled self-assessment, which can be used to measure progress over the length of the program.

Assessment

Due the brevity of the program and the dysregulated affective states of participants, formal assessments of participant change in distress tolerance or decoupling of automatic mental process from behavior may be difficult to achieve in the typical 28 or 45-day format of residential treatment program. Follow up assessment at six months or a year may also be difficult to achieve due to a lack of continuity of services and the instability of the population's social circumstances (homelessness, incarceration, absconding from legal supervision, or simple avoidance) and subsequent limited accessibility. That said, the Distress Tolerance Inventory (DTS) is a measure for distress tolerance based on four subscales: tolerance, appraisal, regulation, and absorption (Hsu et al., 2013; Simons & Gaher, 2005). The DTS displayed good divergent and discriminant validity, good internal consistency, and fair test-retest ability over a six-month period (Hsu et al., 2013; Leyro, Bernstein, Vujanovic, McLeish & Zvolensky, 2011). The DTS may be administered at intake, or during the initial treatment planning process, to

obtain a baseline score. The DTS may be administered again at discharge to ascertain variance in distress tolerance.

The Five Faceted Mindfulness Questionnaire (FFMQ) can be employed to assess non-reactive acceptance and decoupling. The FFMQ uses a 1-5 Likert scale to measure what is most generally true about five mindfulness factors: observing, describing, acting with awareness, non-judgment of inner experience, and non-reactivity to inner experience (Curtis et al., 2011). The FFMQ measures increases in the five facets of mindfulness in relation to increases in meditative experience, and it was found to have good construct validity and adequate to good internal consistency (Baer et al., 2008). Although there are 39 items on this questionnaire, which may seem daunting, the questions are brief and the questionnaire may be completed quickly. The FFMQ is also easily accessible on-line. Like the DTS, the FFMQ would be applied at the on-set of the program to establish baseline scores, and then again as part of an exit interview so that scores may be compared.

Intended Audience

Although this curriculum may be employed by a clinician providing services to anyone experiencing acute or post-acute withdrawal as a result of substance abuse recovery, it has been designed for providers working with a Level III population (ASAM, 2013). Level III care (3.1 to 3.5) is defined by ASAM as clinically managed and high intensity services that are provided in a residential setting (ASAM, 2013). Further, Level III services are provided 24-hours a day in a secure environment to provide stability in the event of multi-dimensional, substance use related, imminent danger. Also, Level III care should provide services that address co-occurring substance abuse and mental health issues, as well as being capable of providing assistance with

medical, legal, educational, vocational, parenting and other issues which may inform success in recovery (ASAM, 2013).

The need for providing services to this particular population is due to the fact that continuity of services from residential to outpatient or aftercare is not guaranteed, and rates of relapse and program attrition during this transition in level of care is typically high due to the client's withdrawal distress, intense urges and cravings (Acquavita et al., 2013; Carter et al., 2008; Lindahl et al., 2013; Luoma et al., 2014). Given this knowledge, it is essential that residential treatment provides tools and interventions, such as this modification to urge surfing, that directly target distress tolerance, urges, and craving to a population that desperately needs it.

Conclusion

Craving and avoidance of the distress of withdrawal symptomology are primary causes for substance abuse relapse (ASAM, 2011, Tiffany et al., 2012). Through the development of non-reactive acceptance, MBRP urge surfing works to decouple automatic mental processes, from coping behaviors and increases tolerance for distress, both of which foster resilience in recovery (Bowen et al., 2011; Ostafin & Marlatt, 2008; Turner et al., 2013). For participants in early recovery or higher levels of care, however, inefficient cognitive function due to acute and post-acute withdrawal may impede the use of an essential component of urge surfing, which is abstract visualization (Manning et al., 2008; Narayanan et al., 2012; Niikura et al., 2013; Wollenweber et al., 2014).

A proposed means of resolving this impediment is to replace abstract visualization with a juxtaposition of stillness and somatic agitation to precipitate urges and cravings in the exercise. Somatic agitation and distress are not only available, but in most cases unavoidable, as a result of acute and post-acute withdrawal symptomology (APA, 2013; Buffalari et al., 2012; Lutz et al.,

2014; Perney et al., 2012. Therefore, these resources are lived experiences, which are readily available to acute and post-acute populations.

In support of a somatic approach, research related to yoga based therapies suggests that posture induced immediate somatic distress can be instrumental in facilitating affective change and reducing reactivity to stress (Schmalzl et al., 2015; Spinazzola et al., 2011; Wren et al., 2011; van der Kolk et al., 2013). In reviewing these findings as a whole, it becomes apparent that somatically based approaches influence the perception of stress, anxiety level, and negative affective states (Jindani et al., 2015). In addition, somatic interventions have also been shown to influence neurochemical changes, such as the increase of GABA and decrease of cortisol (Curtis et al., 2011; Reddy et al., 2014; Streeter et al., 2007), which may directly support individuals attempts at prolonged recovery. These studies support an argument for somatic urge surfing by demonstrating that juxtaposing concrete and immediate somatic distress with stillness (i.e. holding postures) is a credible mechanism for precipitating automatic mental processes such as urges and cravings.

Although yoga related research suggests that induced somatic distress can be harnessed to precipitate affective and physiological states, it is not necessary in the case of a residential recovery population to use challenging physical posture towards that end. Somatic distress, similar to that experienced while holding yoga postures, such as muscle tremors, restlessness, shakes, and other autonomic nervous system manifestations, is already present due to acute and post-acute withdrawal. In order to precipitate therapeutically productive cravings and urges in program participants for the process of urge surfing, the visualization component of this intervention can be replaced with an attentional focus on concrete and immediately available somatic sensations in the body. Combined with strict physical stillness, this focus on bodily

sensations will create a similar result to that of a challenging yoga posture, which is the urge to end or alter the experience. Program participants can then cultivate awareness, acceptance, and non-reactivity to urges and cravings by this venue, until such time as post-acute withdrawal symptomology resolves and a more nuanced cognitive approach can be employed.

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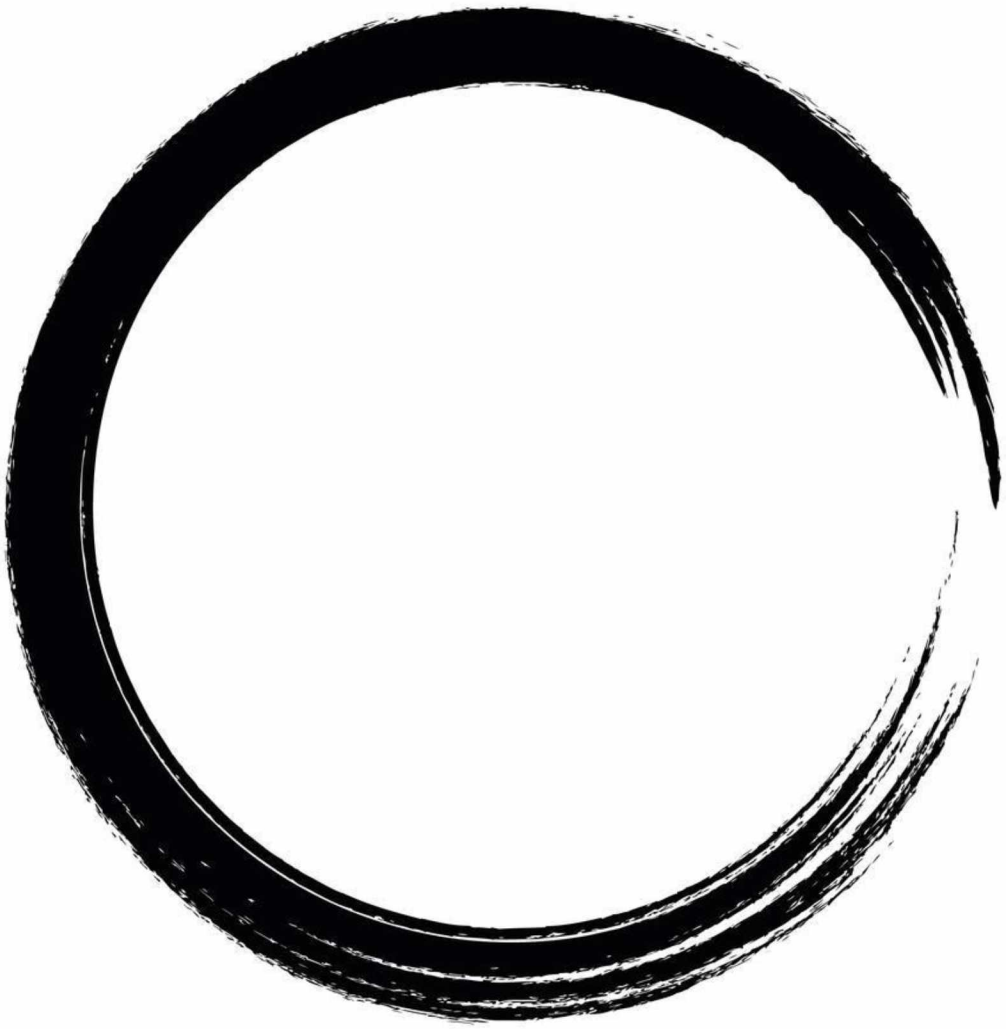
APPENDEX



SOMATIC URGE SURFING

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Table of Contents

INTRODUCTION

Rationale

In 2014, as an outpatient substance abuse counselor working with a felony offender diversion program in Fairbanks, Alaska, I came across the urge surfing intervention in a clinician's manual for Mindfulness-Based Relapse Prevention written by Bowen, Chalwa, and Marlatt (2011). This intervention rapidly became a standard piece of the group work due to its simplicity and power in helping clients manage craving. Feedback from group participants as to the efficacy of the urge surfing intervention was consistent over time and it appeared to be a dependable and useful recovery tool. As such, it was with a good deal of confidence that I introduced urge surfing to group in the residential setting.

This confidence was misplaced, and the intervention was not effective. The participants were in early recovery, struggling with post-acute withdrawal symptoms, including inefficient cognitive function (a.k.a. brain fog in popular recovery parlance), and simply could not engage the visualization which is at the core of the urge surfing technique. An immediate and pragmatic solution was to let go of the visualization and use the withdrawal related physical discomfort that the participants felt as a way to precipitate the urges that urge surfing requires. The urge to move was created by requiring absolute stillness, which in turn created tension between the act of stillness and post-acute withdrawal symptomology, such as shakes, tremors, physical restlessness, and itchiness, among others. This approach yielded the requisite urges and cravings necessary to engage the intervention, as evidenced by consistent in-group feedback from participants over the next year.

The residential treatment program in which this group work occurred is operated by an interior Alaskan tribal organization which serves a significant number of Gwich'in, Tanana, and Koyukon people. Members of

other tribes and nations, including Inupiat, Ahtna, Yup'ik, Aleut, Tlingit, Haida, and Tsimshian as well as non-native participants were also represented in the population. Feedback from group participants on urge surfing was consistently positive, and urge surfing was observably applied on a voluntary basis by program participants in moments of stress. For, this reason, there is some confidence that the modification of urge surfing for this population is a culturally competent practice, although further study and cultural consultation is obviously necessary.

Theory

Urge surfing, as practiced in the Mindfulness-Based Relapse Prevention (MBRP) model, is a method of decoupling automatic mental responses, such as urges and cravings, from coping behaviors, such as substance use (Darbeda, Carre, Orri, Barry, & Lejoyeux, 2015; Larimer, Palmer, & Marlatt, 1999; Ostafin & Marlatt, 2008; Witkiewitz, Marlatt, & Walker, 2005). The urge surfing method applies acceptance and non-reactivity to automatic mental responses, reducing or eliminating the need to produce an action or behavior (Bowen et al., 2011). This approach works to change the individual's relationship to the automatic processes instead of attempting to change those mental processes themselves (Hayes, 2004; Ostafin & Marlatt, 2008; Ostafin, Bauer, & Myxter, 2012: Witkiewitz, Bowen, & Donovan, 2011). Non-reactivity is accomplished through maintaining an aspiration to remain non-judgmental and to avoid any attempt to escape, change, or fix the experience (Turner, Welches, & Conti, 2013). Acceptance and non-judgmental awareness allow for uninterrupted exposure to experiences such as urges and cravings, which in turn leads to a natural extinction of conditioned response to those experiences (Gregoire, 2015). The power of urges and cravings to drive behavior is therefore reduced through the cultivation of acceptance, non-judgmental awareness, and non-reactivity.

MBRP urge surfing involves developing a sustained creative visualization that triggers the urge, impulse, or craving to use a substance of addiction, which can then be employed in the practice of acceptance, non-judgmental awareness, and non-reactivity. In a group setting, clients are encouraged by a group facilitator to visualize a moderately high risk substance using scenario until it triggers a craving or impulse. Participants are then instructed to observe the craving or impulse as if it were a wave, maintaining awareness of the wave with as little reactivity or judgement as possible, and eventually allowing it to subside on its own. Participants are encouraged to "surf" or "be with" this wave and ride out the intensity of it as a way to lessen resistance or reactivity (Bowen et al., 2011; Dharmadikiri & Sinha, 2015; Turner et al., 2013).

Since this visualization process of urge surfing is not possible for some people in recovery, due to various cognitive factors related to early withdrawal, somatically focused urge surfing uses physical discomfort in the same fashion as yoga to precipitate automatic mental responses, such as urges and cravings. In traditional yoga systems, physical discomfort is generated by the use of challenging physical postures which are intentionally held motionless to a point of distress. Distress is then observed with acceptance and non-reactivity (Anderson, 2009; Spinazzola, Rhodes, Emerson, Earle, & Monroe, 2011). Yoga tradition is supported by current research in the assertion that holding the body in a position of distress -- despite an urge or desire to change the position -- develops tenacity, resilience, non-judgment, non-reactivity, and self-control (Anderson, 2009; Schmalzl, Powers, & Blom, 2015; Wren, Wright, Carson, & Keefe, 2011). Somatically focused urge surfing operates on this assumption as well, and it aims to bring tenacity, resilience, non-judgment, non-reactivity, and self-control to bear on substance abuse recovery and relapse prevention processes. Distressing postures are not necessary for somatic urge surfing, as this intervention simply takes advantage of

already existing physical discomfort generated by withdrawal symptoms. Withdrawal related physical distress creates automatic mental responses (urges and cravings) which can be enlisted for use in the urge surfing exercise.

Context

The projected context of this intervention is a Level 3 residential substance abuse treatment program. This intervention is suggested for Level 3 services because urge surfing specifically targets cravings and urges which are the prevailing factors, along with withdrawal symptoms, in relapse and resumption of substance use for individuals in early recovery, residential populations (Hsu, Collins, & Marlatt, 2013; Tiffany, Friedman, Greenfield, Hasin, & Jackson, 2012; Witkiewitz, Bowen, Douglas, & Hsu, 2013). Residential treatment programs at the 3.1, 3.3 or 3.5 level of care are low to high intensity, clinically managed, and run a gamut of durations from four weeks to six months, but these programs commonly follow four to six week protocols (American Society of Addiction Medicine, 2013). The format of this leader guide is predicated on the assumption that this intervention will be offered as a component of a larger multi-dimensional residential treatment program that spans a four to six-week time frame. The format is also based on the assumption that the multi-dimensional approach will necessitate that the urge surfing group session be scheduled on a weekly basis, and will be an integrated component of a thirteen or fourteen group framework (two groups a day) covering a range of recovery related topics, depending on the overall modality of the specific program. In essence, this intervention can be conceptualized as having urge surfing sessions, which build in intensity, occurring each week, and practiced throughout the week as a supplement to other group and individual counseling interventions.

Format

This curriculum has been structured in a manner that reflects multiple counseling modalities. The format reflects the fusion of a standard group

structure (Corey, Corey, & Corey, 2014), an established and widely used modality for urge surfing (Bowen et al., 2011), and somatically based modifications to urge surfing. Elements of standard and established group format are included in the leader guide and consist of affirming group norms, opening check-in and closing comments, check-out, and open or structured processing. These elements provide familiarity, encourage verbal engagement, and foster continuity between sessions (Corey et al., 2014). In addition, each sessions goals, objectives, and recovery context are addressed in the description of each session to orient the facilitator to the potentials and limitations of the participants at a given point in time in a typical recovery trajectory.

Similar to other mindfulness based interventions, post meditation dialogue is part of this intervention (Crane, Stanley, Rooney, Bartley, & Cooper, 2015). The function of the post-meditation dialogue is to explore direct experiences from the exercise, to develop self-knowledge from that experience, and to generalize that experience and knowledge to the other group participants (Crane et al., 2015; Piet, Fjorback, & Santorelli, 2016). The goal of the dialogue for the individual participant's is to reveal automatic and unconscious patterns of thinking and feeling, to reduce cognitive reactivity, and to increase acceptance of negative experiences (Crane et al., 2015). With this function and goal in mind, in the first sessions, dialogue between facilitator and participant may be more focused on allowing knowledge of group process to grow, on acclimating participants to here and now exploration of experience, and on fostering efficacy in self-expression (Crane et al., 2015). Examples of these post-meditation dialogues are provided in the description of each session.

Facilitator

The facilitator's role in the session is to create a collaborative environment that supports safe exploration of urges, cravings, and other automatic mental responses (Bowen et al., 2011). In providing guidance for the urge

surfing exercise, it is recommended that the facilitator adopt a nonjudgmental, non-reactive, and curious attitude that models the capacities being developed by the participants (Bowen et al., 2011). It is preferable to use as little direct or forceful language as possible and to maintain both a light and spontaneous approach (Bowen et al., 2011; McCown, 2016).

Guidance through the exercise should encourage an inviting atmosphere and lead to harmony and compatibility within the group and between facilitator and participants (Crane et al., 2015). For instance, a facilitator may express directions as if the action is already underway to create a sense that a participant is already involved in the process. As an example, a facilitator may state, "finding the breath as it enters and exists the nose, we can…", as opposed to saying, "pay attention to your breath, and…" (McCown, 2016). Additionally, language that avoids a dichotomy of facilitator and participant, or observer and observed, is encouraged in order to increase a sense of inclusion and collaboration. For example, a facilitator may state, "we want to avoid attempting to change the urge" as opposed to saying "don't try to change the urge" (McCown, 2016). Also, actions that may be antithetical to modeling an accepting and non-reactive approach in this context are striving for change, fixing, or problem solving, and they should be avoided (Bowen et al., 2011; McCown, 2016). Finally, the facilitator should practice the exercises along with the participants in order to retain a sense of collaboration and congruence with the group.

OVERVIEW OF SESSION COMPONENTS

Welcome and Group Norms

Welcoming participants can typically be an informal procedure. However, if the welcome is consistent from group to group, it can serve as a non-directive cue that group has started and that group norms, such as the rule of confidentiality, are in effect (Corey et al., 2014). At this point, the facilitator can set the tone for the group, which should be warm, congenial, and inviting (McGown, 2016). Group norms can be gently presented as a necessity for safety, confidentiality, and respect, which will resonate with a group of people who are in deep crisis and are experiencing feelings of vulnerability. An authoritarian or forceful tone, on the other hand, may increase feelings of vulnerability and induce resistance. Beyond the standard group norms of confidentiality and respectful speech, an urge surfing or mindfulness group will require that participants respect silence, avoid offering critiques of the mindfulness experiences of others, and remain in the room until the exercise is completed. Respecting silence and avoiding critique will facilitate a gentler attitude towards self and others. Asking participants to remain in the room contributes to the primary goal of developing acceptance and non-reactivity towards urges and cravings.

Check-In

There is no formal procedure for facilitating the session's check in. A Likert scale, which is a scale from one to ten for rating an experience, is recommended as it is customary, familiar, and concrete, and therefore unlikely to induce a feeling of vulnerability or insecurity in participants. Once a participant has indicated where they are emotionally on the scale, a facilitator may ask the participant to briefly touch on the events during the day that brought them to that number. This is an invitation for participants to speak about themselves without interference from other members, and it can ensure that more reserved group members develop a voice in the group (Corey et al., 2014). Occasionally, a participant may

refuse to check-in. There is no real need to pressure a participant into answering a check-in question, so a reticent participant's need for autonomy in the moment can be supported.

Urge Surfing

Moving into urge surfing, the facilitator can start by briefly explaining to participants that this intervention cultivates acceptance and non-reactivity in order to reduce the power of urges, cravings, and distress. The concept can then be expanded further by explaining to participants that by learning to observe physical or mental sensations without reaction, they can increase their self-control and ability to tolerate stressful situations in general. The facilitator may also offer the idea that acceptance and non-reactivity can have a positive effect on relationships and quality of life, which may reduce stressors before they become problematic.

Next, the facilitator can ask participants to assume an upright, seated posture, not leaning or slouching, but also not absolutely still. If the participants appear to feel uncomfortable in the upright position, explain that a little discomfort is helpful to the exercise as the purpose is to produce an urge to move or change, and mild discomfort will probably cause that urge. Bring the participants attention to their breath as it passes through the nose, into the throat, then the lungs. Ask that they observe the rise and fall of their chest and belly in order to ground themselves in here-and-now awareness of their bodies. Grounding in the body in this fashion serves to counteract dissociative strategies such as absorption or detachment, and it cultivates the ability to stay in the present moment when all of the urge surfing work will be done (Zerubavel & Messman-Moore, 2015). Once participants are grounded in the moment, as evidenced by outward quietude and a concentrated appearance, ask group members to remain as motionless as possible until the exercise is over. Explain that motionless means not moving any part of the body at

all. Sustain participants in a motionless posture until the established time frame has elapsed.

Particularly in the first two weeks of abstinence, participants should experience an array of withdrawal related sensations, such as shakiness, itching, cramping, tremors, spasms, and a strong desire to move, bolt, run, or to mentally check out and put the mind elsewhere may emerge. These sensations will challenge participants and precipitate an urge or craving to respond or move (Perney, Lehert, & Mason, 2012; Pizon, 2015; Schauss, 2012). Explain that should an urge to move, or otherwise change the experience, arise, the participant can observe that urge without reacting to it or judging it (Bowen et al., 2011). Give an example to the group of how this may play out. For instance, you may say, "Your leg may start to get restless, and you will have a desire to shift its position. Rather than shift the legs position, pay attention to your urge to move it, but without reacting, judging, or moving." Encourage participants to observe the urge to move until it passes, watching it increase in intensity and then decrease and disappear, like a cresting wave (Bowen et al., 2011). To end the exercise, bring participants back to a focus on the breath as it moves in and out of the nose. Finally, direct participants to take three deep breaths, holding them in for five seconds each before releasing an exhalation. The function of this concluding activity is to release any tension that may have built up in the body from maintaining strict control over movement.

Post-Exercise Dialogue

Following the urge surfing exercise, the facilitator will explore participant experiences through brief collaborative dialogues. Each participant can be engaged in sequence, going around the group circle, with a turn taking method of inquiry (Crane et al., 2015). Turn taking involves asking a question, listening to the participants answer, and then reformulating the answer back to the participant. The initial question can include specifying elements that limit the answer to experiences that are occurring in the

moment or during the urge surfing exercise. This question should also be non-evaluative, avoiding inquiry related to how or why, and focusing on what is occurring in the moment (McCown, 2016). As an example of turn taking, the facilitator may ask, "What are a few words you would use to describe your experience with this exercise?" The participant may say, "Anxious, annoyed, and uncomfortable". The facilitator can then respond with, "When you pay attention to your body, you experience uncomfortable anxiety" initiating an understanding of the participant's reactivity to internal triggers. Another example may be that the participant responds to the same question with, "I couldn't do the exercise because of this other guy's heavy breathing." The facilitator can then reflect back with "You were distracted from your own work by what was going on with your neighbor", establishing a foundation for understanding the participant's reactivity to circumstances or external triggers. This process creates an environment that is low stress, safe, and validating in which participants can explore experience in terms of triggers, urges, and non-reactivity.

Summary and Check out

At the end of the group process, the facilitator can tie prevalent themes from the session, such as cravings and urges, internal and external distress, or non-judgmental awareness and non-reactivity, to relapse prevention and recovery. The goal of this summation is to generalize individual knowledge and experience to the group and beyond into larger contexts, thereby linking experiences of the moment to the larger learning themes of the intervention or therapeutic model. This process lays the groundwork for integration of participant knowledge into the post-treatment environment (Piet et al., 2016).

Following the summary, the facilitator can provide a brief check out with group members. The functions of this check out are to ensure that no one is leaving group with unmanageable feelings and to allow participants to evaluate their own progress. An example of a well-being checkout is,

"Let's go around and everyone can use one word to describe tonight's group…" In the event of incongruity of responses or self-invalidating comments, the facilitator can intercept the participant and assess for safety concerns or the need for further therapeutic action.

In addition to the well-being checkout, residents may be encouraged to evaluate their progress in developing acceptance and non-reactivity, or in performance of the intervention. The evaluation question can be based on the specific group goal for each urge surfing session. For instance, the goal of session one is simply to learn the method for practicing the intervention. The evaluation question therefore, may be to ask if participants believe that they understand the intervention. As they move through the sessions, a progress evaluation question allows participants to draw their own conclusions about their progress, increasing autonomy and enhancing self-efficacy. As a final activity, ask participants to stop for a few seconds and listen to sounds outside of the room, to pay attention to the immediate moment, and to attempt to carry that momentary awareness into their lives outside of group (Bowen et al., 2011).

OVERVIEW OF SESSIONS

Keep in mind that these sessions are not occurring in a vacuum, and that the development of the group will be impacted by the high intensity group environment occurring for the rest of the week. Although a once a week therapeutic group in an outpatient setting may take several weeks to develop cohesion and alliance, or to move from one developmental stage to another, there may be thirteen other groups (two a day), or more, between one mindfulness group and the next in a residential setting. Yalom (1985) has identified the first twelve group meetings as a critical period of time in a group's development. In some residential programs, the first twelve groups can happen in six days. Speculatively, this environment is going to be a factor in accelerating the group development.

Session One/ Week One

In session one, participants are welcomed and invited to participate. Performance of the somatic urge surfing exercise, as well as group norms and best practices, are explained in detail and the overall focus of the group is established (Ettin, 1992). Initial experimentation with acceptance and non-reactivity to urges and cravings is encouraged during urge surfing. The function of the post exercise dialogue is to establish the turn taking pattern of the dialogue, increase participant's self-efficacy in the group environment, and initiate exploration of tacit experiential knowledge. The line of inquiry for the turn taking dialogue may begin with, "What are three words you would use to describe your experience today?" It is anticipated that participants will engage the group with some hesitance, uncertainty, and lack of confidence and in-group identity, which are all consistent with the initial or forming stage of group development (Corey et al., 2014; Hall, 2015; Yalom, 1985).

Session Two/ Week Two

In session two, the urge surfing technique is used to develop non-judgmental awareness and acceptance of distress or discomfort, and to

decouple automatic mental responses (urges) from coping behavior. The structure of the techniques is briefly reiterated. Participants are encouraged to observe urges and cravings that arise from physical agitation with acceptance and non-reactivity. The goal of this session is to disrupt automatic processes by decoupling urges and craving from mental and physical behavior. The function of the post-exercise dialogue is to instill awareness of mental and physical avoidance strategies that may have arisen during the exercise, such as attempting to ignore the craving, or to shift position in response to an urge. The line of inquiry for the turn taking dialogue may begin with, "When you became aware of a negative sensation, what was the first thought that came to mind?" Some participants may remain hesitant and uncertain in this session. Others may attempt to establish some level of control though negative commentary or advice to peers (Yalom, 1985). Participants may also experience or project anxiety, resistance, and defensiveness, consistent with the emotionality of the transition, or storming stage of group development (Corey et al., 2014; Hall, 2015). The psychoeducational and skills group facilitator's task in this stage is to process affective participant response, and to allay fears (Ettin, 1992).

Session Three/ Week Three

In session three, the scope of the post exercise process is broadened to reveal emotions that may drive automatic mental responses, such as urges or cravings, during the urge surfing technique. The structure of the technique used during previous sessions is briefly reiterated. Participants are encouraged to observe urges and cravings that arise from physical agitation with acceptance and non-reactivity while also taking note of any emotions that may emerge during the exercise. The goals of this session are to strengthen the capacity to disrupt automatic mental responses by decoupling them from behavior, and to gain non-reactive awareness of feelings that may underlay automatic mental responses. Upon completion of the urge surfing exercise post exercise dialogue is facilitated in order to

help participants identify and label emotions that arise during the exercise so that insight may be gained regarding their role in automatic mental processes aiding in the progression to lapse and relapse. The line of inquiry for the turn taking dialogue may begin with, "What are three feelings or emotions you felt during the exercise?" It can be expected that participants may more readily settle into the group tasks of mindfulness activity and credible post-exercise dialogue, which are consistent with the mutual trust and disclosure that can occur in the working, or norming stage of group development (Corey et al., 2014; Ettin, 1992; Hall, 2015; Yalom, 1985). Tasks of the psychoeducation and skills group facilitator are to consolidate boundaries and foster identity, cohesion, and mutuality in the group (Ettin, 1992).

Session Four/ Week Four

In session four, the goal is to integrate somatic urge surfing, acceptance, and non-reactivity into post-treatment recovery efforts. A brief review of the purpose of the exercise is provided. As before, participants are encouraged to observe urges and cravings that arise from physical agitation with acceptance and non-reactivity, while also noting memories of high risk, triggering situations that evoke strong emotional responses. The function of the post exercise dialogue is to lay the foundation for integration of the group experience into post therapy recovery efforts and relapse prevention planning. A line of inquiry may begin with, "Describe one or two high risk situations in which you can use this intervention to keep from using drugs or alcohol in the future." Task completion, including use of prescribed meditation posture and sincere introspection during the post-exercise dialogue, can be expected in this session, which are consistent with either the norming stage, or the final, performance stage of group development (Corey et al., 2014; Hall, 2015). The psychoeducational group facilitator's tasks in this stage of development are to solidify the main didactic points of the group topic, maximize learning, and encourage risk taking and change (Ettin, 1992).

Sessions Five and Six/ Weeks Five and Six

In sessions five and six, the goals are to deepen the experience, acceptance, and non-reactivity through practice, and to expand integration from post-treatment sobriety efforts to other life domains. Participants who have progressed through post-acute withdrawal to a point where visualization is feasible, may be instructed in the use of the Mindfulness-Based Relapse Prevention urge surfing exercise described by Bowen and colleagues (2011). Instruction in these sessions is geared towards application of tools developed through urge surfing to lapse and relapse prevention. The function of the post exercise dialogue is to reinforce participant confidence in the intervention as an alternative action to habitual negative coping behaviors. A line of inquiry may encourage exploration and normalization of broader applications of either urge surfing or the constructs of acceptance and non-reactivity. It is anticipated that participants will be competent, confident, task oriented, and invested in the success of the group in these two sessions, consistent with final, performing stage of group development (Corey et al., 2014; Hall, 2015). Session five and six tasks for the facilitator of a psychoeducation and skills development group are the same as in session four, but with the added responsibilities of reviewing salient points, generalizing the information to across life domains, and fostering participant independence (Ettin, 1992).

CURRICULUM

The next part of this manual provides a six-session leader guide for facilitating an urge surfing group in a residential setting. The curriculum is presented in six separate sections, each consisting of session goals and objectives, context (Keep in Mind), welcome and group norms, check in, urge surfing, post-urge surfing dialogue, and check out. For each component of a session, a procedure is provided followed by a description of what can be expected during the session. Instructions for the facilitator will be indicated with an 'F'. Instructions for participants will be indicated with a 'P'.

Session One/ Week One - 90 minutes

Session Goal: To teach the somatic urge surfing exercise and lay the ground work for exploration of experience in subsequent sessions.

Session Objectives: Create a warm and inviting atmosphere; explain and practice the urge surfing exercise; establish the turn taking pattern of the dialogue; and increase or reinforce participant's self-efficacy in the group environment.

Keep in Mind: During their first session, participants are in either acute or post-acute withdrawal, unless they have had a period of abstinence prior to treatment. They are disoriented and unfamiliar with program rules and expectations. Participants do not know and or trust staff or peers. Inattention, inability to concentrate, and lack of focus are the typical experiences for participants during this stage of treatment.

Facilitator task: Establish the overall focus of the group.

Welcome and Group Norms — 10 Minutes

Procedure:

Warmly welcome participants and establish group norms.

For the Facilitator (F): Explain that the purpose of confidentiality is to create a safe space and that what is said in group, stays in group.

For the Participants (P): Ask everyone to respect silent periods so that others can do their internal work without distraction.

(P) Ask that everyone remain in the group, even if it becomes emotionally or physically intense, as remaining present with experience is an essential aspect of mindfulness practices like urge surfing.

(P) Ask that all speech be respectful and in the best interests of the group.

(P) At this point, also ask if the group would like to establish any group rules beyond those already mentioned in order to foster feelings of collaboration among the participants and ownership of the group

What to expect here: Expect repetitive questioning, incomprehension, and general reluctance to engage. Responses may be single word, non-specific, and global. Participants will look to the facilitator for a sense of security and for guidance.

What to do: Repeat the instructions calmly and with patience as many times as necessary. Allow space for each participant to take risks and engage in the group process as much as they believe they safely can. Avoid pressure and encourage a participant to disclose in a manner that does not compromise their sense of efficacy, agency, and safety.

Check-in **10 minutes**

Procedure:

(F): Using a scale of 1-10, with 1 being very negative and 10 being very positive, ask participants to rate on this scale how they feel at the moment and to briefly describe what occurred in the course of the day that brought them to their current feeling.

(F) Gently limit cross talk or side conversations while participants are speaking. Cross talk and side conversations tend to take power from whoever is speaking, and can serve as a deflection from uncomfortable experiences.

(F) Gently discourage digressions into history beyond the immediate day. The focus of any mindfulness group is typically the here and now. War stories or emotional rants are also rehearsals for relapse.

(F) Proceed in sequence around the group circle so that everyone gets a turn to speak. This ensures that more reserved participants do not get lost amongst more talkative participants.

Note: In the event that a participant does not wish to offer a number or exploration, it is not necessary to push. The wish for privacy and autonomy can be respected.

(F) Aim for a warm, inviting, and engaging atmosphere.

What to expect here: In their first session, expect participants to rate themselves low (1-5). A sense of well-being is at a premium in early recovery. Expect a focus on the negative. Also, expect outward deflection away from the self.

What to do: Maintain an accepting attitude. Receive low numbers and negativity graciously and without judgment. Avoid any kind of fixing or defending. Be completely present with participants as they speak.

Urge Surfing **20 minutes**

Procedure:

(F) Provide a brief description of the somatic urge surfing experience that will be introduced, as well as its purpose. This procedure will remove the unknown and unexpected from the session and reduce apprehension.

(F) Sit facing a clock to mark time or set the timer on a cell phone (use vibrate and turn off the ringer to minimize distraction). Typically, time is precious and must be managed. Keep track so that all of the tasks can be accomplished.

(P) Ask participants to assume an upright posture in their chair – not leaning forward or slouching. Explain that a little discomfort from an unfamiliar posture is helpful to the exercise. Laying down or slouching is traditionally not considered optimal for concentration and focus.

(P) Suggest participants to observe their breath for a few minutes, in order to bring their attention to their bodies. The body exists in neither the past nor the future, but in the present. Attending to the breath in the body brings attention to the task at hand in the present.

Note: Initially, strict stillness is not required.

(P) Breath may be observed as it enters the nose, goes through the throat, into the lungs, and then returns the same way. Offer instruction to participants to feel their chest and belly expand on the inhalation.

(P) Direct participants to now remain as motionless as possible until the exercise is over. Being motionless and still while agitated by post-acute withdrawal will create urges to move for most participants.

(P) Explain that motionless means not moving any part of the body at all.

(F) Practice the exercise as a member of the group to contribute to a feeling of collaboration and alliance.

(F) Role model good posture.

(F) Do not address participants about their individual practice during the exercise. This confrontation will cause more disruption than benefit and can lead to feelings of shame for participants.

(P) Suggest that should a participant feel an intrusive physical sensation – for instance if they itch, start to shake, or twitch – that they maintain simple awareness of the sensation without judging, reacting to it, or moving. Maintaining this awareness is the core activity in this exercise

(F) Sustain participants in a motionless posture until the established time frame has elapsed. The longer the group remains motionless, the more likely an urge to move or adjust will occur.

(F) Do not shorten the time frame unless a safety issue arises.

(P) To end the exercise, direct participants first to observe the breath going into and out of their noses. This is simply to provide a gradual (as opposed to sudden) exit from the exercise.

(P) Suggest participants to take three deep breaths, holding the breaths in for five seconds each before exhaling. Gentle breath retention exercises release endorphins and create a sense of well-being which makes the exercise rewarding, and is a nice way to end.

(F) Provide brief instruction on the value of developing the capacity to have acceptance and non-reactivity towards urges and cravings to use drugs or alcohol. For instance, explain that urges and cravings are normal and unavoidable, and that their power is increased by judgment and avoidance. Accepting urges and cravings non-reactively, and observing them as they rise and then pass, eliminates their power. This brief instruction is intended to give the intervention meaning and purpose.

What to expect here: Participants will be uncomfortable. They will not remain still. Some participants will sigh impatiently. Some will be unaware that they are fidgeting. Some will fall asleep. The occasional participant may suddenly leave the room.

What to do: Focus on completing and explaining the exercise. The facilitator's steadfastness will be calming to participants who may not feel in control. Avoid correction or helping to remain consistent with the goal of acceptance and non-reactivity.

Post Urge Surfing Dialogue **40 minutes**

Procedure:

(F): Engage each participant in turn and proceed around the group circle.

(F) Use a three-step turn-taking dialogue structure, which is as follows:

(F) First ask the participant a question using these approximate words:

> *"What three words would you use to describe your experience during the exercise we just completed?"*

(F) Stay completely in the moment and engage in deep listening as the participant responds. This may require you to mentally repeat each word the participant says in order to shut off your own mental distractions.

(F) Reframe, reflect, or shape the words offered by the participant. For instance, if the participant says, "Itchy, sweaty, and anxious", the facilitator may respond with, "You're experiencing a lot of discomfort right now." Reframing and reflecting are simple skills for showing a participant that they have been listened to and are taken seriously.

(F) Seek affirmation that your reflection was accurate. For example, "Is that right?", or something approximating this question.

(F) Say *"thank-you"* to end that particular dialogue.

(F) Stay brief.

(F) Gently avoid deflection away from the immediate moment, monopolizing time, or storytelling. These are unconscious strategies for disrupting the recovery effort and serve to reinforce addiction.

(F) Move on to the next person and repeat the process.

(F) Although you want to maintain the same approximate question every time, avoid being mechanistic or overly scripted. The objective is not to have iron clad discipline, but to be therapeutically reflexive and predictable.

(F) Open up the discussion to the whole group by asking if anyone has any other observations or thoughts that came up after they spoke.

Frequently, a participant will think of something after their turn has passed and this gives them the opportunity to offer it.

What to expect: Responses in the first session will be generic, global, and low risk. Enthusiasm may be absent. Platitudes are common. For instance, because it's a mindfulness group, participants may offer 'peace, tranquility, and oneness' as their three words, feeling that those are terms a facilitator wants to hear.

What to do: Accept the attitude and the responses in the dialogue, and reframe them back. Perhaps the reframe can involve a common theme. For instance, 'You found it calming.' In essence, model non-reactivity.

Closing **10 minutes**

Procedure:

(F): Summarize themes and make observations about similar experiences that arose in the group in order to generalize them to other group members. At closing you will momentarily have everyone's attention simultaneously, whereas, earlier in the group, participants were inwardly focused on their own processes.

(F) Encourage participants to engage in 10 minutes of urge surfing practice daily. Daily practice will increase confidence, competence, and self-efficacy, increasing the likelihood that it becomes a default response post-program.

(F) Ask group members if they believe that they understand how to perform the exercise. Answering this question will give participants a way to measure progress through the program, increasing autonomy and self-efficacy.

(F) Be aware of signs that a participant is emotionally dysregulated or in an unmanageable state such as self-invalidation, negative expressions, or protective and closed body language.

(F) Inform potentially at-risk individuals that you would like to speak with them for a moment before they leave the room. When group is over, and confidentiality can be achieved, explain to them that you feel that they are dissatisfied in some fashion and wonder if there is anything you can do. Ask them how they feel about group; whether there is anything that they did not get to say during group; or if there is anything that they want to talk about. Listen deeply. Ask the participant if they can suggest a solution. If there is an identifiable risk, develop a safety contract, or take other necessary or mandated protective action.

(F) Express gratitude for everyone's participation, offer respect, and provide support. If group members took risks, make a general statement to the group that there was some courageous work done, and that you appreciate and respect those risks being taken (without singling anyone out). If the group was a "good one", offer that feedback.

What to expect: Responses will remain non-committal and safe. Outward affect may be flat. It may be difficult to tell if a participant is paying attention.

What to do: Model non-reactivity and remain positive.

Session Two/ Week Two - 90 Minutes

Session Goals: To engage in the urge surfing technique and decouple automatic mental processes from coping behavior.

Session Objectives: Develop a consistently safe and inviting atmosphere; increase participants' awareness of automatic mental processes (urges and cravings); develop participants' awareness of the temporary nature of urges and cravings; increase participant's ability to verbalize thoughts related to distress and urges; and to create or deepen acceptance, non-judgement, and non-reactivity to aversive experience.

Keep In Mind: In the second week of program, participants are in post-acute withdrawal and experiencing both mental and physical dysregulation (brain fog and agitation). They are oriented to program rules and expectations. Some alliances with peers have been formed and relationships with staff are established. Raw emotions, verbal expression, inability to focus or concentrate, inattention, and rule testing are the norm.

Facilitator Task: Process participant emotionality, and allay participant fears and anxieties.

Welcome and Group Norms — 10 Minutes

Procedure:

The procedure is essentially the same as that described in Session One.

Welcome participants and continue establishing group norms.

For the Facilitator (F): Review the purpose of confidentiality which is to create a safe space by re-emphasizing that what is said in group, stays in group.

For the Participants (P): Remind everyone to respect silent periods so that others can do their internal work without distraction.

(P) Review the importance of everyone remaining in the group, even if it becomes emotionally or physically intense.

(P) Reemphasize the importance that speech be respectful and in the best interests of the group.

(P) At this point, also ask if the group would like to establish any group rules beyond those already mentioned.

What to expect: Some participants may question the group rules or the value of the exercise. They may also express dislike for the exercise on religious (or non-religious grounds). Some participants will continue to appear reserved.

What to do: First, offer that the rules are there to create safety, respect, and to ensure that the exercise strengthens recovery. Second, ask if the group would like to add any rules. Third, take a vote from the group approving any suggested new rule. Explain that the exercise is a method for controlling one's own mind and not a spiritual practice.

Check-in **10 minutes**

Procedure:

The procedure here is essentially the same as in Session One. Use a scaling check in to process emotions at the beginning of group. Gently encourage group members to follow the rules of good collaboration and respectful group conduct during the check in, similar to the previous session.

What to expect: Participants may still check-in with low self-rating numbers, but they will disclose emotions and motivators; some externalization may occur. For example, "I'm a 3 because I'm angry at OCS and the prosecutor who treated me like a criminal in court yesterday." Some participants may decide not to check-in at all as a boundary test.

What to do: Reflect the emotion, but not the external cause. Bring the reflection into the present. As an example, "So, todays a 3. You're angry

right now." If participants opt out of the check-in, support their decisions. With a respectful and accepting demeanor, simply say "OK", and move to the next person.

Urge Surfing **20 minutes**

Procedure:

This week, instruction in the urge surfing exercise is the same as that described in Session One, with the following exceptions:

(P) Suggest that should a participant feel an intrusive physical sensation – for instance if they itch, start to shake, or twitch – that they maintain simple awareness of the sensation without judging, reacting to it, or moving. Further suggest that should an urge to react to the sensation arise, that the participant shift focus to that urge, observing it with gentle curiosity.

(F) Sustain participants in a motionless posture until the established time frame has elapsed. The longer the group remains motionless, the more likely an urge to move or adjust will occur.

(F): Provide a brief instruction on the temporary nature of thoughts, urges, and cravings. For instance, explain that urges and cravings are mental occurrences that do not last. Describe the arcing trajectory of urges as they begin, build in intensity, and then disappear completely. Explain, that this arcing, wavelike process may take, on average, between seven and ten minutes sometimes. Also explain that the very nature of addiction is to escape or avoid uncomfortable feelings or sensations and by escaping or avoiding urges and cravings, addictive behavior is continued.

What to expect: Participants in the second week may still be uncomfortable. If they are put off by the exercise, they will clearly express it at the beginning. During the exercise, participants will also attempt to control their urges, cravings, and desires, rather than to accept them non-reactively. This control will typically result in a short period of tight, rigid

stillness, followed by unceasing movement that will last for the duration of the exercise. For instance, a participant may adopt a posture with eyes tightly shut, arms straight into thighs, and hands balled up. Then, they will observably collapse, surrender, and fidget. A few participants may leave the room.

What to do: Complete the exercise without comment. At the end of the exercise, simply state to the group, "The more you try to control urges and cravings, the more powerful they become, until you give them all of your power, leaving yourself with none." Avoid further explanation. Let the statement provoke introspection.

Post Urge Surfing Process **40 minutes**

Procedure:

The post-urge surfing dialogue is the same as that found in Session One, with use of a three-step turn-taking dialogue structure.

(F) For Session Two, begin the dialogue using these approximate words:

> *"When you became aware of a physical sensation, what was the first thought that came to mind?"*

(F) Although a three-part turn taking interview is desirable here, a participant may have difficulty identifying bodily sensations and associating them with a thought. Some additional assistive dialogue may be necessary. Care must be taken not to create failure in front of peers or to otherwise shame. If the participant is unable to produce a thought or feeling within a short time frame, shift to an affirmation of their effort, encourage them to keep exploring, and take the focus off of them. Focus is shifted off a participant to avoid shame, embarrassment, or a sense of failure that may inhibit future exploration or effort.

(F) Follow the rest of the procedure as described in section one.

What to expect: Expect some participants to offer non-direct responses that do not completely answer the question.

What to do: If participants are experiencing difficulty, tell them you will come back to them. When you come back to that participant, gently and respectfully (be careful to avoid condescension) bring the conversation into the immediate moment with a simple question which focuses on a safe body part such as, "Are your hands hot or cold right now?" Follow this question with, "What's one word that comes to mind when you think of your cold (or hot) hands?" With this line of questioning, the participant can practice observation of bodily sensations using a safe body part, followed by simple observation of thoughts and emotions. This also allows the participant to complete the exercise successfully.

Closing **10 minutes**

Procedure:

As with the previous sessions, close the group by summarizing themes, encouraging practice outside of group, watching for at-risk behavior, and ending on a positive note.

What to expect: At this point, participants may offer negative self-assessment of efficacy and self-deprecation, often with humor. Also, negative experiences within the exercises may be disclosed and global (i.e. not specific) emotional states can be expressed in a cathartic fashion. For example, "I couldn't get my leg to stop twitching and it drove me insane!" Or, "I couldn't stop thinking about my boyfriend who overdosed a year ago. It hurts so much." Because of the safe release of emotions and new bodily awareness, participants may express that this was a particularly "real" or powerful group

What to do: Model acceptance and non-reactivity. Express amusement with the self-deprecating humor, but do not joke or respond with humor. Respond to negative self-assessment by expressing that discomfort is

common with a new activity and explain that it takes practice to become good at it. Relabel intrusive negative physical sensation as a positive development that is useful for the exercise. Empathize with intrusive emotional experience and make yourself available for a brief after group one on one.

Session Three/ Week Three - 90 minutes

Session Goal: Cultivate awareness of thoughts and emotions informing automatic mental processes

Session Objectives: To create an atmosphere that is warm, safe, and inviting to exploration; provide an opportunity for participants to identify and label thoughts and emotions that inform automatic mental processes; strengthen participant non-reactivity towards urges, cravings, or thoughts/ emotions that arise.

Keep in Mind: In the third week, participants remain in post-acute withdrawal and are experiencing both mental and physical dysregulation (sleep disturbance being a major factor), but symptoms are considerably reduced compared to the prior week. There is a degree of acceptance of the routine in group and treatment overall. Ability to focus or concentrate is still impaired. There is some limited optimism due to length of sustained abstinence.

Facilitator Task: Consolidate boundaries and norms, and foster identity, cohesion, and mutuality in the group.

Welcome and Group Norms — 10 Minutes

Procedure:

Again, the procedure here is essentially the same as in Session One.

(F) Welcome participants and remind them that norms and rules such as confidentiality and respect are in place.

What to expect: Participants may settle into group more readily, and even look relieved to be in this particular group (because it's relaxing and calm). There will most likely be little questioning of the group norms as participants now know that compared to other groups in the program, structure is light and pressure is low.

What to do: Model non-reactivity and reinforce the warm atmosphere with a welcoming and relaxed attitude. Smile at people and greet them as they

enter the room. Ask if everyone is comfortable with the norms and rules without reciting them. If someone does not remember the rules, review them.

Check-in **10 minutes**

Procedure:

As in Session One, the procedure here is essentially the same.
Use a 1-10 scale, or some other creative rating system, to allow emotional check in and validation of that emotional experience.

What to expect: Most scaled self-rating numbers will be above five. Although some participants will remain hesitant, many or most will give a sincere rating and explain it fully to the group. In the case of opiate users, reticence may be related to social antipathy (e.g. contempt) that arises in withdrawal. In the case of stimulant users, reticence may be a result of depression-like symptoms arising from withdrawal as well.

What to do: Continue to model acceptance. Stay present in the moment and use deep listening (repeating each word to yourself silently to shut off your own mental distractions) when participants speak so that they feel heard and valued. Gently encourage hesitant participants to disclose. Should a participant not wish to rate themselves, engage them in a brief bantering dialogue to non-aggressively create the opposite effect of non-participation. For example, the facilitator may ask, "You're not going to say how you're doing?" The participant may say, "Nope." The facilitator response may be, "But, now I'm going spend the rest of the day wondering how you're doing." The participant may respond with a shrug, or say, "That's largely your problem, boss." The facilitator may then respond with "Alright. It's cool. You control the message." The participant has now engaged in a non-performance related and non-shaming dialogue which is not only the opposite of non-participation, but that eclipses the time and energy of simply participating. The content of the conversation is

immaterial as long as it is not punitive, directive, or shaming. It is now more likely that the participant will choose the lesser of two evils in the next session and simply rate themselves.

Urge Surfing **20 minutes**

Procedure:

The urge surfing procedure remains essentially the same as in Session One, with participants being reminded to observe urges and cravings that arise from physical agitation with acceptance and non-reactivity.

For the Participant (P) Suggest to participants that they take note of any emotions that may emerge during the exercise. (This information will be used during the dialogue.)

For the Facilitator (F) After the exercise is complete, provide a brief instruction on the difference between thoughts and emotions, and on the connection or chain between external or internal triggers, thoughts and emotions, urges or cravings, and coping behavior. For instance, it may be explained that while thoughts can often be controlled, emotions cannot. While emotions must be acted upon, the choice of action is within participant control. Triggers cause thoughts or emotions, or both, which in turn result in urges to act. Urges result in behavior or action. Point out that emotions, thoughts, and behaviors are different events, and that, after thoughts and emotions arise, they do not have to automatically proceed one from the other.

What to expect: In their third session, participants are likely to assume the meditation posture they have established for themselves in a fairly rapid fashion. They will for the most part, begin observance of their breath before the facilitator instructs them to do so. Some will have started this observance during the check-in. Body movement from agitation will still be evident. Participants may "involuntarily" move and then make facial expressions indicating disappointment in themselves. A few participants

may have decided that meditation is not for them and will read a book, doodle, or stare out the window. Some will fall asleep.

What to do: Model acceptance. If a participant is enthusiastic, simply allow them to have the experience. If there was a good deal of agitation related movement, express to the group that when they do not meet their own expectations in the exercise, they can extend acceptance and non-reactivity to that experience too. If a participant is not enthusiastic, but non-disruptive, allow them the space to decide for themselves. If a participant falls asleep, let them sleep unless they snore (It is typically a very quiet and low energy group. Sleep is inevitable). If they snore, very gently wake them up, as snoring will disrupt the other participants.

Post Urge Surfing Process **40 minutes**

Procedure:

(F) Using a turn taking dialogue structure, follow the same basic procedure as in Session One using the following approximate words:

"What are three feelings or emotions you felt during the exercise?"

(F) Staying in the moment and engaging in deep listening remain critical elements to this dialogue.

(F) When a participant offers three words, for instance "vulnerable, idiotic, and overwhelmed", take one of the words and ask what action the word urges them to take. For example, *"You said vulnerable. What does feeling vulnerable make you want to do?"* The participant may say, "*It made me want to protect myself."*

(F) Address only one of the participant's words, in the interest of time.

(F) When the participant identifies the emotional action, reflect the action back, but separating the emotion from the action. For instance, *"When you feel vulnerable, you respond by protecting yourself."*

What to expect: In their third session, participants will most likely disclose emotions with little effort. Some will have trouble articulating feelings due to lack of vocabulary and require assistance.

What to do: If a client is having trouble identifying emotions, tell them you will come back, and take the focus off of them. When you come back, focus the exercise on the immediate moment and ask, "Can you name one emotion you felt during the exercise?" When the participant discloses any emotions, or even thoughts (resist the urge to "expertly" correct), say something encouraging like "perfect" and "thank-you". Then, encourage the participant to keep working on the original question and take the focus off of them.

Closing **10 minutes**

Procedure:

As with the previous sections, the closing remains the same: summarize themes, encourage practice outside of group, ask participants to rate their competence, watch for at-risk behavior, and close on a positive note.

What to expect: Participants who have bought in to the exercise will disclose confidence in their ability to perform it. Participants may also express epiphanies or insights related to the chain of behavior specific to their personal addictive habits, regardless of their participation in the exercise. There may also be the first expressions of over confidence and the sense that they've "got this". Participants may have advice for their peers and engage in cross-talk.

What to do: Support and affirm the conclusions reached by the participants. Point out that confidence in the exercise is the first step to using it as a tool for recovery and is not the end result. Also, point out that every participant will have a unique experience.

Session Four/ Week Four - 90 minutes

Session Goal: To integrate urge surfing and non-reactive awareness and acceptance into the post-residential recovery environment.

Session Objectives: Create a warm and inviting atmosphere that reduces defensiveness or resistance; identify internal or external triggers that provoke negative thoughts and emotions; develop non-reactive acceptance as a positive coping mechanism that can replace substance use; learn somatic urge surfing as an in-the-moment intervention for cravings and urges; initiate group termination

Keep In Mind: Participants in the fourth week of program remain in post-acute withdrawal and are experiencing mental dysregulation which may be subtle and concealed by apparent competence (maintaining an appearance of progress). The predictability of the routine is comforting and disruptions of routine are destabilizing. Ability to focus or concentrate is considerably improved, but still impaired. Most participants are optimistic about their length of abstinence.

Facilitator Task: Solidify the main points of the group topic, maximize learning, and encourage risk taking and change.

Welcome and Group Norms **10 Minutes**

Procedure:

For the participants (P) Open with a statement to the effect that the group is now over halfway complete. Offer brief praise for the groups progress so far. State that there are two more groups after this one.

(P) Remind participants that the purpose of confidentiality is to create a safe space and that what is said in group, stays in group.

(P) Reiterate that it is best if everyone respects silent periods, remains in the group, and uses respectful speech.

(P) Indicate that it is still an option to suggest new group norms or rules.

What to expect: Participants may demonstrate impatience with the opening formalities arising from existing familiarity with the rules and a desire to practice the exercise (It's calming and tranquil, something that most people recovering from addiction value).

What to do: Keep the presentation of the rules and norms brief, as in fact, the participants do know them.

Check-in **10 minutes**

Procedure:

For the facilitator (F) Using a scale of 1-10, ask participants how they feel at the moment and to briefly describe what in the course of the day brought them to their current feeling.

(P) Gently limit cross talk or side conversations while participants are speaking.

What to expect: Self-rating may be in the higher numbers, barring negative events in the treatment environment or disruptions from post-acute withdrawal (such as a week four crash and potential relapse for recovering methamphetamine users). All participants will typically be engaged and offer both a rating and a description of the day. Cross talk can be an issue throughout the group as participants are very familiar and comfortable with each other and the facilitator.

What to do: Model acceptance. Encourage and support feelings of competence and success. Gently remind the group as a whole that cross talk and side conversations can exclude more soft spoken group members, can be carried out elsewhere, and are encouraged as a way to support peers between groups.

Urge Surfing **20 minutes**

Procedure:

The urge surfing procedure remains the same as in the previous three sessions.

(F) Before starting, ask if there are any clarifying questions about urge surfing specifically. Ask if any problems have arisen when participants have practiced urge surfing on their own.

(F) If you are aware that this is a particularly engaged group, state that you won't tell them how to do the exercise because they know what to do already. This approach increases self-efficacy and conveys confidence and respect.

(F) Practice with the group.

(F) After completing the exercise, provide a brief instruction on the use of urge surfing as an immediate intervention that can be used when faced with cravings to use substances.

Intervention:

When you feel the urge to use drugs or alcohol:

Stop whatever you are doing.

Find a place to sit.

Decide to remain motionless for one hundred breaths.

Count your breaths.

As the craving increases in intensity, allow yourself to be aware of it without reacting to it – as though you are watching someone else's child playing in a park.

Don't make the craving go away.

Don't respond at all.

Stay focused on the breath.

If the craving is still there at one hundred breaths, count another hundred breaths.

Repeat as necessary.

When the craving passes, recognize that you are in control and that the craving does not exist at the moment.

What to expect: Most participants will easily adopt the meditation posture and appear quiescent and concentrated. Participants who have been reluctant up to this point may none the less remain respectfully still and appear concentrated. Some previously hesitant participants will attempt all or part of the exercise.

What to do: Model acceptance and non-reactivity. Allow participants to engage at whatever level they feel comfortable without commentary.

Post Urge Surfing Process **40 minutes**

Procedure:

(F) Using the same format as in Session One, ask the participant a question using these approximate words:

"Describe a situation that could lead you to use right now. How would you use urge surfing to resolve it?"

(F) Stay completely in the moment and engage in deep listening as the participant responds.

(F) Reformulate the response and seek affirmation as you have in previous sessions.

What to expect: At this point, with at least four weeks of abstinence, participants can typically engage in speculation. They will have no difficulty imagining high risk situations; however, some participants will have trouble producing urge surfing solutions as they have not integrated acceptance and non-reactivity into real life situations.

What to do: *In the dialogue, reframe the participant's response so that it reflects acceptance and non-reactivity. For example, if the participant says, "If I were to pull up a couch cushion and find an empty plastic bag that smelled like weed, it would make me want to call my dealer."*

The reformulation could be*, "If you were to pull up a couch cushion and find an empty plastic bag that smelled like weed, it would make you want to call your dealer. So, you would recognize that you were having an urge to use, and you could observe that urge without reacting to it." The reformulation offers an alternative to the participants default behavior, which demonstrates that while urges and cravings may be inevitable, the response to them is a choice.*

Closing **10 minutes**

Procedure:

(F) As was done in Session One, summarize themes that arose in the group related to automatic mental and physical responses.

(F) Make observations about similar responses to the exercise from different group members (without singling anybody out).

(F) Sum up common feelings expressed by the group

(P) Encourage participants to engage in ten minutes of urge surfing practice daily.

(P) Check-out by asking group members to rate on a scale of 1-10 how likely it is that they will use urge surfing as an intervention for craving.

(F) Remain aware of high risk individuals in the group and be prepared to intervene as described in Session One.

(P) Express gratitude for everyone's participation, respect, and support and end on a positive note.

What to expect: Participants will rate their understanding of the exercise in the high numbers (on a scale of 1-10). Some participants will be very optimistic. Some participants will be frankly less confident about whether they can maintain their sobriety and will voice this fear. Most will express that this is a valuable tool. Some participants will voice that they have already been using the intervention whenever they have felt an urge or craving. Participants will demonstrate apparent competence (maintaining an appearance of progress).

What to do: As a closing statement reiterate that, while confidence is good, overconfidence can lead to complacency, and complacency leads to relapse. A useful analogy for this situation is that if you take your eye off the ball, the ball will hit you in the back of the head.

Session Five/ Week Five - 90 minutes

Session Goal: To extend urge surfing and non-reactive awareness as a daily practice beyond recovery into other life domains

Session Objectives: Create a warm and inviting atmosphere for mindfulness activities; expand urge surfing options beyond the somatic format; explore non-reactive acceptance and awareness in relation to family, finances, career, mental growth, spirituality, and physical health; continue to prepare participants for group termination.

Keep in Mind: In week five, participants remain in post-acute withdrawal (which can last 90 days or more) and are experiencing cognitive impairment which may be subtle and concealed by apparent competence. The predictability of the routine is comforting to participants and there is trust in clinical staff. Ability to focus or concentrate is considerably improved but still impaired. At the same, some participants are beginning to doubt their ability to maintain abstinence post-program.

Facilitator Tasks: Maximize learning, encourage risk taking and change, review salient points of the group, generalize the information across life domains, and foster participant independence.

Welcome and Group Norms **10 Minutes**

Procedure:

(P) Open the group with a reminder that this is the second to last group.

(P) Review group norms with participants, as has been done in the previous sessions.

What to expect: Participants will be knowledgeable about group norms and expectations. They typically will enforce these rules themselves without guidance or structure from the facilitator.

What to do: Avoid complacency and stay present with the group. Model acceptance and non-reactivity.

Check-in **10 minutes**

Procedure:

(F) Check in with participants using the procedure and format from Session One.

What to expect: Participants will present carefully considered ratings of their emotional states. They will observably reflect before answering. Many or most will describe their feelings as they are in the moment. Some may soften the intensity of the moment with humor or playfulness. Participants may verbalize anxiety about post-treatment relapse.

What to do: Listen carefully without distraction and accept whatever the participant offers. Functionalize anxiety, explaining that it is reasonable under the circumstances, and that it can be used to increase vigilance in recovery. Encourage participants to non-reactively accept their relapse anxieties just like they would an urge or craving.

Urge Surfing **20 minutes**

Procedure:

(F) Offer instruction in the Mindfulness-Base Relapse Prevention urge surfing format as described by Bowen, Chawla, and Marlatt (2011).

(P) Ask participants to begin the exercise as they have in every session prior, with good posture and observance of the breath. Allow a few minutes to pass in order to achieve a level of quiescence and concentration.

(P) Next, ask participants to imagine a situation that may cause them to have an urge or craving for their substance of choice. Suggest that the situation not be so high risk as to be inescapable or unmanageable. Wait for a few minutes to allow participants to develop the scenario.

(P) Then, ask participants to keep playing out the scenario until they feel an urge or craving. When participants feel that urge, they are to do nothing with it, other than to be aware of it as it grows in intensity, like a swelling

wave, and then subsides. Wait a few minutes so participants can develop this phase of the exercise.

(P) Gently suggest that participants, "Accept the urge without reacting to it." Then wait a few minutes so that participants can experiment with the experience.

(F) Practice the exercise as a member of the group.

(F) Role model good posture.

(F) Do not address participants about their individual practice during the exercise.

(F) Do not shorten the time frame unless a safety issue arises.

(P) To end the exercise, direct participants first to observe the breath going into and out of their noses.

(P) Suggest that participants to take three deep breaths, holding the breaths in for five seconds each before exhaling in order to release any tension that may have built up in the body.

(F) Following the urge surfing exercise provide a brief instruction on the AA/ 12-Step Serenity prayer as it relates to non-reactive awareness.

The Serenity Prayer is:

God grant me the Serenity to accept the things I cannot change;

The courage to change the things I can;

And the wisdom to know the difference.

(F) The key points are that decoupling urges from actions creates a gap between them where options based on beliefs and values can be considered. While thought and emotion driven urges cannot be changed, there are many options for action that can be placed in the gap, such as non-judgement or some other healthy choice. Non-reaction and non-

judgement lead to serenity by removing the imperative to do something under duress. It takes courage to face the emotions and urges and to choose other unfamiliar options for addressing them. Knowing the difference between the urge to act and the action is wisdom.

What to expect: Most participants will readily engage the exercise in a sincere fashion due to their task completion orientation and high level of investment in the group. There will, however, be discomfort given the new format.

What to do: Reemphasize that discomfort is to be expected in a new activity. Remind participants that urge surfing during Session One was uncomfortable for them as well, although it isn't now. Offer the analogy of learning to drive a standard (stick) shift. It takes practice to do it smoothly.

Post Urge Surfing Dialogue **40 minute**

Procedure:

(F) The dialogue in sessions five and six will be different than in the previous sessions.

(P) At the beginning of the dialogue, ask the group to draw a circle on a piece of paper and divide the circle into six pie wedges. Ask the group to label each pie wedge. The labels can be family (relationships, children), mental development (education, training), career (job, occupation), finances (savings, debt), spirituality (religion, faith), and physical health (illness, fitness).

(F) The same life domain circle can be redrawn or re-used for session six.

(P) Ask participants to list events or circumstances that are unavoidable and out of their control in each domain. The point of this section of the exercise is to raise awareness of places in life in which acceptance and non-reactivity will be of obvious value.

(P) Proceeding around the circle, ask each participant to describe one domain and what is out of control in that domain.

As an example, a participant may respond by choosing family, and state that he or she has no control over an unruly step-child.

(P) Ask the participant what emotion is felt right now while thinking about that situation

An example response might be, "*I feel very anxious. I mean right now, I'm here. But when program is over, I have to go back and deal with it."*

(P) Ask the participant to speculate on the use of urge surfing to address the emotion.

An example response might be, *"Well, when the anxiety rises up, I can sit back and look at it and wait it out without reacting."*

(F) Reformulate the participant's response back to them. For example, "*You can look at the anxiety without reacting to it."*

(P) After all participants have had a chance at dialogue, open up the discussion to the whole group by asking if anyone has any other observations or thoughts that came up after they spoke.

What to expect: As with the urge surfing exercise, participants will typically make a sincere effort on this exercise. Participant insight into triggering situations, thoughts and emotions, urges, and actions will be considerably progressed from earlier sessions, as evidenced by their ability to break the scenario down along the lines of those constructs without assistance. For most, responses during the dialogue will be more concrete and specific than several weeks prior.

What to do: It may be useful to point out that most in the group had some difficulty with this kind of thing in the beginning. Observe that the groups skill level is considerably higher.

Closing 10 minutes

Procedure:

Close this group as you have all previous groups with a summary of themes, a scaled self-assessment of competence in the urge surfing exercise, vigilance for at-risk individuals, and end on a positive not.

To this closing, add that as the following session is the last session, feedback would be appreciated at that time, although it is always welcome.

What to expect here: Most participants will rate themselves lower with this new urge surfing format. Many will also give feedback during this group, instead of waiting, some of which may be uncomplimentary. Participants may also be self-critical as a result of reflecting on life domains. The overall effect on the group may be negative in appearance.

What to do: In the interest of time management, ask that the feedback be written down and offered in the last session. If the feedback is offered anyways, as will happen, model acceptance and non-reactivity. Allow the critical self-reflection from the life domains to run its course without comment, unless there appears to be a safety issue. Suggest to participants that they can apply acceptance and non-reactivity to self-blame as well as they can to urges and cravings.

Session Six/ Week Six - 90 minutes

Session Goals: As in Session Five, the first goal is to extend urge surfing and non-reactive awareness as a daily practice beyond recovery into other life domains. The second goal is termination of the group.

Session Objectives: Create a warm and inviting atmosphere for mindfulness activities; empower participants to practice urge surfing at whatever level they are comfortable; explore non-reactive acceptance and awareness in relations to family, finances, career, mental growth, spirituality, and physical health; provide opportunities for feedback; and offer closure to participants.

Keep In Mind: In the sixth week, participants remain in post-acute withdrawal. Participants attribute a good deal of their success to the program and clinical staff. Ability to focus or concentrate is considerably improved. Participants are preoccupied with separation and fear for the future.

Facilitator Tasks: Maximize learning, review salient points of the group, generalize the information across life domains, foster participant independence, process participant sense of loss, and termination.

Welcome and Group Norms **10 Minutes**

Procedure:

(F) Review group norms with participant as has been done in the previous sessions.

What to expect: As in Session Five, participants will be knowledgeable about group norms and expectations. They typically will enforce these rules themselves without guidance or structure from the facilitator.

What to do: Model acceptance and non-reactivity. Focus on maintaining a warm and accepting environment for the participants.

Check-in **10 minutes**

Procedure:

(F) Check in with participants using the procedure and format from Session One.

What to expect here: Scaled rating numbers will typically be high. Participants may begin to emotionally take leave of the program while describing their feelings (e.g. make concluding statements or testimonies, describe an internal sense of accomplishment and optimism, explain how much better this program is than previous other programs).

What to do: Focus on warmth and acceptance. Facilitate an environment that is positive for this important experience. Keep it light.

Urge Surfing **15 minutes**

Procedure:

(P) Offer participants the choice to follow the format for urge surfing from Session One or to use the MBRP urge surfing format from Session five. Briefly describe each.

(F) Following the urge surfing exercise, briefly describe examples of situations in which urge surfing can be used as an intervention. For instance, when tempted by something (like dessert), when about to do something that you have decided not to do anymore (like eating dessert), or when torn between long term goals (losing weight) and short term desires (dessert).

What to expect: Most participants will easily adopt the now familiar and comfortable meditation posture, appear quiescent and concentrated, and fall into the urge surfing exercise without direction. Participants who were resistant in the beginning will typically maintain a quiescent and concentrated demeanor, even if they are not engaged in the exercise. There will be little to no alternative activity, except in special circumstances.

What to do: Model acceptance and non-reactivity. Allow participants to engage at whatever level they feel comfortable.

Post Urge Surfing Process **40 minute**

Procedure:

(F) Repeat the life domain exercise from Session Five, using a different domain than the session before.

(F) Open the group up for a brief unstructured discussion of any topic related to urge surfing, automatic mental processes, or acceptance and non-reactivity.

What to expect: There will be a consistently high level of competence and confidence in participation in the exercise, perhaps from reflection on the previous session. Scenarios may be detailed. Some participants may use enhanced versions of the scenario from the previous session (this is likely, in fact). There will for the most part be good comprehension of the urge surfing skill of acceptance and non-reactivity. Participants may also disclose insights and epiphanies into the impact of their actions across domains (AA/ NA style testimonials).

What to do: Keep the focus on the core aspect of the exercise, which is acceptance and non-reactivity, by showing support (nodding, smiling, single word affirmations) for any statements, insights, or epiphanies that demonstrate acceptance and non-reactivity.

Closing **15 minutes**

Procedure:

(P) Afford participants the opportunity to share what they have learned from the group.

(P) Next allow participants to identify any changes that they perceive in themselves between the first group and the last, if any.

(P) Then provide participants the opportunity to rate their competence with urge surfing, acceptance, and non-reactivity.

(P) Finally, open the floor to any unfinished business or unstated viewpoints. Normalize feelings of loss by identifying them as a natural part of separations and endings.

(F) End the group on a high note with gratitude and appreciation.

What to expect: While voicing some trepidation about their ability to stay sober, participants will typically provide an upbeat and positive perception of changes, learning experience, and competence. Unfinished business will usually take the form of expressions of solidarity with peers. Participants will characteristically seek ways to continue contact with the group post-termination as a means of mitigating feelings of loss and separation.

What to do: Ensure that all participants have a voice in the process so that they feel empowered as they exit the program. If a participant expresses a desire to continue contact with the group, it is a good opportunity to encourage continuing outpatient, aftercare, or community support group activity.

CONCLUSION

This concludes the group leader guide for somatic urge surfing in a residential treatment program. By the end of this process, participants should demonstrate competence at performing the urge surfing exercise and verbalize an understanding of its application in high risk relapse situations and as a daily practice for supporting sobriety. In addition, participants should be able to articulate a clear experiential understanding of the separation between previously fused or coupled mental events such as urges and cravings, and actions or behaviors.

It is important that a facilitator's expectations for observable results be moderated by a number of considerations. First, there are many unforeseen factors, such as relapse and use while in program, different participant capacities, or even unforeseen legal issues, that may disrupt an orderly or observable progression. Second, the urge surfing exercise, like much of what happens in residential treatment, may not bear fruit until well after a participant has completed program. Third and finally, residential treatment participants are usually enduring post-acute withdrawal, which can persist well after the program is complete and may prove obstructive to measuring permanent change. In this case, like meditation teachers and counselors everywhere, the group facilitator may have to be content with simply walking their talk, which means non-reactively and non-judgmentally accepting participant skill acquisition alone as an indicator of success in the moment.

Suggested Readings

For further information on urge surfing and mindfulness approaches to recovery, here are some suggested readings.

- *Mindfulness-Based Relapse Prevention for Addictive Behaviors: A Clinician's Guide* (Bowen, Chawla, & Marlatt, 2011). This clinician's guide from the creators of urge surfing details an aftercare program for substance abuse

recovery, and is the best source for a description of urge surfing as it is conceived by its originators.

- *Surfing the Urge* (Griffin, 2010). This is an on-line interview for the website Inquiring Minds with the late Dr. G. Alan Marlatt, the originator of the Relapse Prevention recovery and Mindfulness-Based Relapse Prevention approaches, and the urge surfing exercise. This interview is a clear and concise explanation of the philosophy of urge surfing, urges and cravings, and non-reactivity.

- *Surfing the Urge: Experiential Acceptance Moderates the Relation Between Automatic Alcohol Motivation and Hazardous Drinking* (Ostafin & Marlatt, 2008). This is a more technical research article that provides evidence for the effectiveness of urge surfing at decoupling urges and cravings from coping responses such as drinking or using drugs.

- *Being Is Relational: Considerations for Using Mindfulness in Clinician-Patient Settings* (McCown, 2016). This article describes, among other things, the most optimal mindset of a mindfulness group facilitator.

- *Hold It Right There: Build Strength and Confidence* (Anderson, 2009) This article describes the benefits of non-reactivity to physical discomfort from a hatha yoga perspective.

A Final Thought

This curriculum is an attempt to extend a powerful method for cultivation of acceptance and non-reactivity to a recovery population in dire need of concrete and pragmatic ways to address fundamental processes that contribute to relapse. The offered intervention arose from a collaboration between a facilitator and group participants exploring recovery from addiction in a multicultural therapeutic environment. As a result, while awareness, acceptance, and non-reactivity are the mechanism for change that drives the intervention, non-

dichotomous collaboration is at the heart of this curriculum. It is only through a respectful and collaborative spirit that an exploratory, inclusive, and unbiased environment can be fostered that will allow the undefended space necessary to develop non-judgmental acceptance. Consequently, it is hoped that this curriculum will be used not only as a specific tool for confronting the challenges posed by urges and cravings to early recovery, but as a starting point for development of an overall environment characterized by fairness, equality, and justice.

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